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

In the Matter of the Accusation against:

A. GRANT KINGSBURY, M.D.

Physician's and Surgeon's Certificate No. A 64822

Respondent

Case No. 800-2017-038069

OAH No. 2019020525

DECISION AFTER NON-ADOPTION

Theresa M. Brehl, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on July 22, 23, and 24, 2019, in San Diego, California.

Keith C. Shaw, Deputy Attorney General (DAG), Department of Justice, State of California, represented Complainant Kimberly Kirchmeyer, Executive Director, Medical Board of California (Board), Department of Consumer Affairs, State of California (Complainant).

Robert W. Frank, Attorney at Law, Neil, Dymott, Frank, McCabe & Hudson, represented Respondent A. Grant Kingsbury, M.D. (Respondent).

The matter was submitted on July 24, 2019. The ALJ issued a Proposed Decision on August 21, 2019.

On November 22, 2019, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by Panel A on January 30, 2020, with ALJ Coren Wong presiding. DAG Keith Shaw represented Complainant. Respondent was present and represented himself. Panel A, having read and considered the entire record, including the transcript and the exhibits, and having considered the written and oral argument, hereby enters this Decision After Non-Adoption.

SUMMARY

This disciplinary proceeding arose after a review of coroner reports uncovered that one of Dr. Kingsbury's patients committed suicide in May 2013 by overdosing on several medications, including hydrocodone and alprazolam prescribed by Dr. Kingsbury. Complainant sought to discipline Dr. Kingsbury's physician's and surgeon's certificate based on allegations that during his care and treatment of the patient Dr. Kingsbury committed gross negligence, repeated negligent acts, and repeated acts of clearly excessive prescribing of drugs; failed to maintain adequate and accurate medical records; demonstrated a lack of knowledge; and prescribed dangerous drugs without an appropriate prior examination and a medical indication. The allegations concerned Dr. Kingsbury's prescription of Vicodin (a combination of hydrocodone and acetaminophen), zolpidem (Ambien), and alprazolam (Xanax) to the patient. Complainant requested that Dr. Kingsbury be placed on probation with appropriate terms and conditions as recommended by the *Medical Board of California Manual of Model Disciplinary Orders and Disciplinary Guidelines* (12th Edition, 2016) (Disciplinary Guidelines).

Dr. Kingsbury did not dispute that he made serious mistakes during his treatment and care of the patient and that his medical record keeping was not up to the requisite standards. Dr. Kingsbury acknowledged that when the patient was under his care, he was aware of the patient's prior history of intravenous drug abuse and that the patient suffered from liver disease and opioid dependence and/or addiction. Dr.

Kingsbury admitted he allowed the patient to manipulate him and he mistakenly believed, at the time the patient was under his care, that he was the best physician for the patient. Dr. Kingsbury expressed his shame, humiliation, and regret for the manner in which he cared for the patient. He asserted that he had since sufficiently changed his prescribing and record keeping practices to assure that nothing similar ever happens again. Dr. Kingsbury argued that a public reprimand was warranted under the circumstances.

Complainant proved by clear and convincing evidence that Dr. Kingsbury engaged in gross negligence, repeated negligent acts, and repeated acts of excessive prescribing; failed to maintain accurate and adequate medical records; demonstrated a lack of knowledge; and prescribed dangerous drugs without an appropriate prior examination and a medical indication. Based on the evidence presented, a 35-month term of probation, with conditions requiring supervision and additional training, is the necessary and appropriate level of discipline to assure public protection under the circumstances.

FACTUAL FINDINGS

Licensing and Jurisdictional Background

1. On April 10, 1998, the Board issued Physician's and Surgeon's Certificate No. A 64822 to Dr. Kingsbury. His certificate was in full force and effect at all times relevant to this proceeding and will expire on December 31, 2019, unless renewed. There have been no prior disciplinary actions against Dr. Kingsbury's certificate.

2. Complainant signed the accusation in her official capacity on January 3, 2019. The accusation alleged Dr. Kingsbury subjected his certificate to discipline pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), by committing gross negligence in his care and treatment of the patient (First Cause for Discipline); pursuant to Business and Professions Code sections 2227 and 2234,

subdivision (c), by committing repeated negligent acts in his care and treatment of the patient (Second Cause for Discipline); pursuant to Business and Professions Code sections 725, 2227, and 2234, by committing repeated acts of clearly excessive prescribing of drugs to the patient as determined by the standard of the community of physicians (Third Cause for Discipline); pursuant to Business and Professions Code sections 2227, 2234, and 2266, by failing to maintain adequate and accurate medical records regarding his care and treatment of the patient (Fourth Cause for Discipline); pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), by demonstrating a lack of knowledge in his care and treatment of the patient (Fifth Cause for Discipline); and pursuant to Business and Professions Code section 2242, subdivision (a), by prescribing dangerous drugs without an appropriate prior examination and a medical indication (Sixth Cause for Discipline).

3. Dr. Kingsbury timely submitted a notice of defense, and this hearing followed.

Dr. Kingsbury's Education, Background, and Medical Practice

4. Dr. Kingsbury is an internist and primary care physician. He is not an addiction or pain management specialist. He obtained his Bachelor of Science Degree in Psychobiology from Pitzer College in 1984; his Master of Science Degree in Physiology from the University of California, Davis in 1988; and his Medical Degree from Loyola Stritch University School of Medicine, in Chicago, in 1996. He completed an internship in internal medicine in 1997 and an internal medicine residency in 1999, both at the Scripps Mercy Hospital Internal Medicine Program. After finishing his residency, Dr. Kingsbury worked for Scripps Mercy Medical Group in Poway, California from August 1999 to December 1999 and for Graybill Medical Group in Poway, California from December 1999 to May 1, 2000.

5. On May 1, 2000, Dr. Kingsbury acquired an internal medicine private practice in San Diego, California, which he has continued to operate and has always operated as a solo practitioner. He has typically had five or six employees, including medical assistants, billers, and front desk personnel. His office is across the street

from Scripps Mercy Hospital, and in addition to his office-based practice, Dr. Kingsbury sees patients at Scripps Mercy Hospital. Dr. Kingsbury estimated that he typically sees patients for one-third to one-half of the time he is in the office, and he spends the rest of the time, when he is not at the hospital, doing charting. Dr. Kingsbury pointed out during his testimony that he strives to maximize the amount of time he spends with each patient. In order to allow him to spend more time with each patient, he does not take notes between patients. Instead, he does his charting later. Approximately two percent of his patient population have been treated for pain, which amounted to 20 to 30 patients.

6. For the past 18 years, Dr. Kingsbury has also provided internal medicine consultations in the Behavioral Health Unit at Scripps Mercy Hospital. He does this work six days a month and he is "on call" 24 hours during those days. Dr. Kingsbury described his work in the Behavioral Health Unit as "more difficult" and said it "stretches him," meaning that it takes him out of his "comfort zone." A lot of patients in that unit suffer from substance abuse disorders and dual diagnoses, including patients diagnosed with bi-polar disorder and personality disorders. With the patients in that unit, communication may be more difficult, the patients may not always tell the truth, and they may be manipulative. Dr. Kingsbury noted that there can be some anxiety associated with caring for those types of patients.

7. Additionally, Dr. Kingsbury has taught new residents and interns at Scripps Mercy Hospital for the past 18 years. University of California San Diego (UCSD) Medical School students also participate in that training. Dr. Kingsbury estimated that he has spent about 20 to 25 percent of his professional time teaching. In 2018, Dr. Kingsbury received an award from UCSD for being a "teacher of excellence" at Scripps Mercy Hospital.

8. Dr. Kingsbury received San Diego Magazine's "Top Doctor" award in the field of Internal Medicine in 2012. He was elected by his peers and was quite proud of receiving that award, which was publicized in the May 2012 issue of the magazine.

Treatment of Pain and the Opioid Crisis

9. The treatment and care of the patient at issue in this matter occurred during a time when the extent of what is now commonly referred to as the "Opioid Crisis" was not fully understood in the medical community. When Dr. Kingsbury was trained as a doctor, he learned that pain should be treated as the "fifth vital sign." However, treatment of pain with opioid medication has changed since Dr. Kingsbury became a physician, and he explained during his hearing testimony that he has come to understand the number of opioid prescriptions peaked during 2011 and 2012. Dr. Kingsbury submitted a May 5, 2017, article titled "The Joint Commission's Pain Standard: Origins and Evolution," which described the history of the assessment and treatment of pain. That article was received as administrative hearsay and was considered to the extent it supplemented and explained Dr. Kingsbury's and complainant's expert Robert M. Franklin, M.D.'s testimony. (Gov. Code, § 11513, subd. (d).)

10. During the timeframe when the patient was treated by Dr. Kingsbury, the Board's "Guidelines for Prescribing Controlled Substances for Pain" (adopted in 1994 and amended in 2007) (Pain Treatment Guidelines) were in effect.[1] The Pain Treatment Guidelines explained that the standard of care had "evolved over the past several years" such that a physician was "permitted to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances." The Pain Treatment Guidelines stated: "The Board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly, and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists"; "[m]edications, in particular

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[1] Dr. Franklin considered these guidelines when forming his opinions, which are described later in this decision.

opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, or cancer"; and "opioid analgesics for patients with pain may also be beneficial, especially when efforts to alleviate the pain with other modalities have been unsuccessful." However, the Pain Treatment Guidelines also cautioned:

> Inappropriate prescribing of controlled substances, including opioids, can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs.

The Medications at Issue in this Matter

11. This case focused on Dr. Kingsbury's prescriptions of Vicodin, alprazolam (Xanax), and zolpidem (Ambien)[2] to the patient. Dr. Franklin's expert report, which was received in evidence without objection, supplied information about these three medications, both Dr. Franklin and Dr. Kingsbury testified about these medications, and the scheduling of these drugs is set forth in the code sections cited below.

12. Vicodin is a combination of hydrocodone and acetaminophen and was, at the time, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and

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[2] Although the accusation listed Citalopram, a selective serotonin reuptake inhibitor (SSRI) and Clonazepam (known by the trade name Klonopin) as among the "pertinent drugs," there were no allegations in the accusation, nor was evidence presented at hearing, that either of those two drugs was prescribed by Dr. Kingsbury. Additionally, even though Complainant's expert provided opinion testimony about another medication, the antidepressant Lexapro (escitalopram), there were no allegations in the accusation that Dr. Kingsbury subjected his certificate to discipline by prescribing that drug to the patient.

Professions Code section 4022. In 2014, Vicodin was rescheduled as a Schedule II drug (Health & Saf. Code, § 11055, subd. (b)(1)(I)).The Vicodin tablets Dr. Kingsbury prescribed to the patient were 5/500 strength, meaning each tablet contained 5 mg of hydrocodone and 500 mg (or 0.5 g) of acetaminophen. Hydrocodone is an opioid pain medication and acetaminophen is the generic name for the analgesic/antipyretic medication commonly referred to by the brand name Tylenol. The maximum daily dose anyone should take of acetaminophen is 4,000 mg per day (or 4 g per day). For long term use, a lower maximum dose of 2,000 to 3,000 mg is commonly recommended. Additionally, limiting the dose to no more than 2,000 mg per day is safer for patients with liver disease. Therefore, the maximum number of Vicodin 5/500 tablets someone without a compromised liver should take was 8 tablets per day (so as not to exceed 4,000 mg (or 4g) of acetaminophen per day), and the best practice for someone with liver disease would be to limit consumption to 4 tablets per day (no more than 2,000 (or 2g) of acetaminophen per day). Acetaminophen toxicity can generally occur in two patterns: acute toxicity due to overdose or chronic toxicity from excessive use over time.

13. Alprazolam (also referred to by the brand name Xanax) is a short acting benzodiazepine and a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is used for management of anxiety disorders. When combined with opioids, benzodiazepines, such as alprazolam, can cause respiratory suppression and profound central nervous system suppression. The prescriptions Dr. Kingsbury wrote the patient for alprazolam were all 0.5 mg strength tablets.

14. Zolpidem (also referred to under the brand name Ambien) is a non-benzodiazepine hypnotic of the imidazopyridine class and is a central nervous system suppressant. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug pursuant to Business and Professions Code section 4022. Zolpidem is used for the short-term treatment of

insomnia. The zolpidem prescriptions Dr. Kingsbury wrote the patient were all 10 mg strength tablets.

Dr. Kingsbury's Treatment and Care of the Patient

15. The evidence of Dr. Kingsbury's treatment and care of the patient consisted of the patient's medical records, a CURES[3] report of prescriptions dispensed by pharmacies to the patient, two letters from Dr. Kingsbury, the transcript of Dr. Kingsbury's subject interview, and his hearing testimony. The patient's medical records did not clearly or consistently state what medications were prescribed or when, and there were no prescription records offered as evidence. Dr. Kingsbury explained during his hearing testimony that he no longer had the prescription records because, at the time, he only maintained paper prescription records, which were kept separate from the medical records, and the prescription records were shredded after one year if there were no problems with the prescriptions.[4] Beginning in 2009, the medical records consisted primarily of electronic progress notes and electronic telephone encounter notes. Dr. Kingsbury used an electronic "eClinicalWorks" medical record system. Using that system, he could "lock" the electronic records. While the telephone encounter records received as evidence were "locked," Dr. Kingsbury was not in the habit of "locking" the progress notes. When he printed the progress notes to

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[3] The Controlled Substance Utilization Review and Evaluations System (CURES) is a database of all Schedule II, III, and IV controlled substance prescriptions dispensed in California. (See Health & Saf. Code, § 11165 et seq.) A CURES report regarding all the prescriptions dispensed to the patient during the relevant time period, printed on January 7, 2016, was received in evidence. Dr. Kingsbury's medical records did not include any CURES or similar reports printed during the course of his treatment of the patient.

[4] However, the fact that the patient overdosed on medications Dr. Kingsbury prescribed would appear to be a "problem" with the prescriptions, which arguably might have warranted retention of those records.

be given to the investigator in 2018, the progress notes were then locked and signed on the date they were printed. While records could have been modified before they were locked, Dr. Kingsbury denied making any changes to the electronic medical records after he treated the patient and/or before he submitted the records to the investigator.[5]

16. The accusation included allegations dating back to 2003. However, the accusation also clearly stated in a footnote that any conduct occurring more than seven years before it was filed was only alleged for informational purposes and was not alleged as the basis for any discipline.[6] While Dr. Kingsbury's treatment and care of the patient before 2012 may not be the basis for discipline, the history of such prior treatment was important to understand the information Dr. Kingsbury had about the patient during his care and treatment from January 2012 through May 2013.

JANUARY 2003 THROUGH DECEMBER 2011

17. The patient's first visit with Dr. Kingsbury was on January 28, 2003, when the patient was 56 years old. Dr. Kingsbury remained the patient's primary care physician for over 10 years through the patient's last office visit on May 8, 2013, when the patient was 66 years old. At the first office visit in January 2003, the patient reported a history of intravenous drug use during the 1960s, hepatitis C in 1969, gastroesophageal reflux disease (GERD), club foot, and that he had quit using alcohol

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[5] Complainant did not allege Dr. Kingsbury falsified or otherwise altered the medical records.

[6] Business and Professions Code section 2230.5, subdivision (a), states: "Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first."

in 1987. Dr. Kingsbury treated the patient for a variety of conditions over the years, including GERD, back pain, and hypertension (HTN).

18. On September 22, 2009, Dr. Kingsbury began prescribing the patient Vicodin 5/500, one tablet as needed for pain every six hours. On a Progress Note, dated September 27, 2010, Dr. Kingsbury recorded that the patient was taking Vicodin "as a cough suppressant - has no pain"; the patient's "Cough - responds to vicodin";[7] and Dr. Kingsbury prescribed one tablet of 5/500 Vicodin every six hours "as needed for pain."

19. On November 21, 2011, Dr. Kingsbury learned that both the patient and the pharmacy had concerns about the patient's consumption of Vicodin. Dr. Kingsbury received the following telephone message taken at 9:30 a.m. that day: "pt states is going to stop taking the hydrocodone, and there might be some problems. he would like to have you call him today and discuss this problem." Dr. Kingsbury spoke to the patient later that day and wrote the following "Action Taken" at 10:13:53 a.m. on the November 21, 2011, telephone encounter record:

> [W]ill quit the vicodin, feels it's an addiction, wants to wean [*sic*] it - was up to 14/day, now down to 8/day. wants to go lower - I recommended he begin with 7/day x one week, then 6/day for one week, etc until weaned - still on naprosyn vicodin was mainly to suppress a cough for work - *ST[8] - please call in vicodin #240 2 qid prn pain w 1 refill to above rite aid - also, please call him to schedule a "Welcome to Medicare" physical exam.

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[7] The capitalization and punctuation are quoted verbatim from the medical records in this decision.

[8] "ST" were the initials of Dr. Kingsbury's medical assistant.

At 11:54 a.m. the same day, Dr. Kingsbury's medical assistant provided Dr. Kingsbury the following message on the same telephone encounter record:

> [I] called in the vicodin to pt's pharmacy, however the pharmacist Janet is uncomfortable and unwilling to fill prescription because pt. is at toxic level. he has picked up hydrocodone these following days #180 7/11, 7/28, 8/16, 8/3, 9/14, 9/29, 10/11, 10/22, 10/28 and now i called in with increase dosage of vicodin. please advise.[9]

Dr. Kingsbury responded at 12:17:38 p.m. that day on the same telephone encounter record:

> [U]nderstood - the patient has made a verbal contract with me TODAY to reduce his vicodin intake over the next few months. He will see me shortly for his physical exam. The problem is being addressed. Tell them we authorize the vicodin as we ordered. Tell them no refills, give #240.

20. According to CURES, the pharmacy dispensed 240 Vicodin tablets to the patient on November 21, 2011, and dispensed another 180 tablets of Vicodin, less than 30 days later, on December 12, 2011, also prescribed by Dr. Kingsbury. Although Dr. Kingsbury stated on November 21, 2011, that he did not authorize any refills, there

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[9] The parties spent a considerable amount of time presenting testimony regarding whether it was reasonable for Dr. Kingsbury to expect the pharmacist to notify him if refills were being sought earlier than Dr. Kingsbury intended. However, based on this message, Dr. Kingsbury knew, as of November 21, 2011, that the patient had been obtaining monthly supplies (then in 180 tablet quantities) of Vicodin from the pharmacy in two to three-week intervals from July 11, 2011, through November 21, 2011.

was nothing in Dr. Kingsbury's medical records for this patient regarding authorization of the 180 Vicodin tablets dispensed to the patient on December 12, 2011.

21. The patient saw Dr. Kingsbury for an examination on December 20, 2011. The Progress Notes for that office visit stated the following under HPI (History of Present Illness): "more stresses, has to go back to work - (out of money)," "takes the hydrocodone for the cough, currently tapering it to reduce overall use," and "took 10 of the vicodin today." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The list of medications the patient was taking included: "Hydrocodone-Acetaminophen 5-500 MG Tablet 4tabs up to 10tabs a day." Under "Plan," there was a subheading for "**2. Hepatitis C without hepatic, not otherwise"** (Bold emphasis in original) which included the following notation: "strict warning about reducing Tylenol intake - 8/d max for vicodin (should be less in the next couple weeks)."

JANUARY 2012 THROUGH SEPTEMBER 23, 2012

22. According to CURES, the patient obtained another 180 tablets of Vicodin on January 19, 2012 (four days before his next appointment on January 23, 2012), prescribed by Dr. Kingsbury, but there was no notation in the medical records regarding this prescription being given to the patient.

23. The patient next saw Dr. Kingsbury on January 23, 2012. The Progress Notes stated under HPI: "sleeping well," "to start work in sales again, feels well, now wants 3 vicodin," and "fasting, wants some lab work - wants to check liver function." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The medications being taken included: "Hydrocodone-Acetaminophen 5-500 MG Tablet 2-3tabs qd." The Progress Notes for this office visit did not say anything about tapering off the Vicodin.

24. The CURES report showed that the patient obtained 30 zolpidem (10 mg) prescribed by Dr. Kingsbury on January 24, 2012. However, there was no indication in the Progress Notes for the January 23, 2012, office visit that zolpidem

had been a medication the patient was taking or that it had been prescribed. Additionally, although Dr. Kingsbury testified that he prescribed zolpidem to the patient for insomnia, the January 23, 2012, Progress Notes did not indicate the patient suffered from insomnia and instead stated, "sleeping well."

25. The patient saw Dr. Kingsbury again on February 3, 2012, for a follow up after an emergency room visit due to a syncopal (fainting) episode. The Progress Notes for that visit stated that the patient was "sleeping well," and did not include Vicodin or zolpidem on the list of medications being taken by the patient. Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

26. The patient had another office visit with Dr. Kingsbury on February 8, 2012. The Progress Notes for that visit said the patient was "sleeping well," and did not mention zolpidem. Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The Progress Notes also stated that the patient was taking "Hydrocodone-Acetaminophen 5-500 MG Capsule 1 capsule as needed for pain Orally every 6 hrs." Similar language was included under the "Plan," but there was nothing stated about tapering anywhere in the Progress Notes for this visit.

27. According to the CURES report, another 30 zolpidem pills, prescribed by Dr. Kingsbury, were dispensed to the patient on February 18, 2012, and another 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on March 1, 2012.

28. On March 14, 2012, the patient called Dr. Kingsbury's office asking that zolpidem and Vicodin prescriptions be faxed to Walmart, and Dr. Kingsbury's written response on the telephone encounter record was "done."

29. The CURES report did not show any medications dispensed by Walmart, but it showed that the Rite Aid Pharmacy that usually filled the patient's prescriptions dispensed 30 zolpidem to the patient on March 14, 2012. There was no record in the CURES report that the patient filled a Vicodin prescription on or near March 14, 2012.

The CURES report also showed that another 30 zolpidem tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on April 9, 2012.

30. The patient's next office visit was on April 25, 2012. The Progress Notes stated the patient was "sleeping well." There was also a notation that "labs done 4/13 and ast/alt and alk phos elevated."[10] Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The medications being taken included: "Hydrocodone-Acetaminophen 5-500 MG Capsule 1 capsule as needed for pain Orally every 6 hrs" and "Zolpidem Tartrate 10 MG Tablet take 1 tablet by mouth at bedtime if needed for insomnia." Nothing was mentioned about tapering.

31. According to the CURES report, 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on May 4, 2012, and 30 zolpidem tablets, also prescribed by Dr. Kingsbury, were dispensed on May 6, 2012.

32. During April and May 2012, the patient was seen by an Ear Nose and Throat (ENT) specialist due to chronic sinusitis and surgical intervention was recommended. On May 24, 2012, the patient had sinus surgery. Later that day, the patient left a telephone message for Dr. Kingsbury at 6:30 p.m., reporting that he had sinus surgery that day and he was in a lot of pain. The message stated the surgeon had given the patient amoxicillin, "but no pain meds and no sleeping pills left." At 6:42:08 p.m. that day, under "Action Taken," Dr. Kingsbury wrote: "called in vicodin #30; he has to pay cash. He got #180 on the 4th of May per pharmacist; also he got #30 zolpidem 5/4, so he can't have more of those."[11]

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[10] Alanine transaminase (ALT), aspartate transaminase (AST), and alkaline phosphatase (ALK phos) refer to lab work performed to check the patient's liver function.

[11] The CURES report showed that 30 zolpidem tablets, prescribed by another doctor, were dispensed to the patient on May 25, 2012. Dr. Kingsbury was not then checking CURES, he did not have that information while treating the patient.

33. On June 4, 2012, Dr. Kingsbury received another message that: "Pt called and states that he would like to speak to you about the [*sic*] his meds. Pt is having a hard time sleeping and is really going through a hard time. Could you please call him?" Dr. Kingsbury wrote the following under "Action Taken" that day:

> [L]ots of pain w recent sinus surgery – can't sleep – "detoxing" from "all those drugs" – not taking vicodin not working, "over the worst" of the pain – no pain meds, due to "heart to heart" with his girlfriend *called in alprazolam[12] .5 mg 1 qhs prn insomnia #20 w 1 refill, to use 4-5x/week.

34. According to the CURES report, 20 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on June 4, 2012.

35. The patient called complaining of fatigue on June 13, 2012, and Dr. Kingsbury saw him for an office visit the next day. The "Chief Complaints" listed in the Progress Notes for that (June 14, 2012) visit were "Discuss sleep issues/fatigue/pain in feet and legs." Under HPI, it stated the patient was "sleeping well," "Done with the narcotics now - he's over the need for this," "sleeping better with xanax," "went through serious withdrawal from the narcotics - diarrhea, sweats, poor eating - now better," and "has aches and pains in feet/knees." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." Included in the list of medications taken were "Xanax 0.5 MG Tablet 1 tablet Orally qhs prn insomnia." Under "Plan" was written: "keep the xanax to 3x/week to avoid dependence - a potential problem for him."

36. According to the CURES report, 20 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on June 23, 2012.

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[12] This was the first prescription of alprazolam; Dr. Kingsbury ceased prescribing zolpidem once he started prescribing alprazolam.

37. On July 12, 2012, the patient called requesting a refill of Xanax. Under "Action Taken," Dr. Kingsbury wrote: ".5mg #30 1 qhs prn insomnia w 2 refills." According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on July 13, 2012; August 7, 2012; and September 1, 2012.

38. On September 17, 2012, the patient called for another refill of Xanax. Under "Action Taken," Dr. Kingsbury wrote: ".5mg #30 1 qhs prn insomnia w 3 refills." According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on September 17, 2012.

SEPTEMBER 24, 2012, THROUGH MAY 7, 2013

39. On September 24, 2012, Dr. Kingsbury received the following message: "Pt is experiencing severe lower back pain, he states it was a birth defect. He would like to speak over the phone or he would like an Rx for hydrocodone. Please advise." Under "Action Taken," Dr. Kingsbury responded: "vicodin #180 w no refills, 1-2 qid prn pain."

40. Dr. Kingsbury testified that when he "reinstituted" Vicodin beginning in September 2012, he tried to be "more judicious" because the number of tablets before November of 2011 had been "quite high" and the patient had struggled to reduce the medication before. Dr. Kingsbury conceded that he was aware that the patient was "very capable of misusing" for reasons "other than pain." Dr. Kingsbury felt that if he restarted the patient on Vicodin, he needed "tighter control" and he also needed to avoid exposing the patient to too much acetaminophen. Dr. Kingsbury, therefore, typically prescribed 180 tablets or less.

41. According to the CURES report, 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on September 25, 2012, and 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on October 8, 2012.

42. The patient called for a refill of Vicodin on October 17, 2012. That day, Dr. Kingsbury authorized the refill and wrote the following under "Action Taken":

> I would like to know WHY he is using so many vicodin. He tried so hard to get off of these, succeeded in doing so, now has used one month's worth in 3 weeks. please ask him what is going on and that I'd like to see him here soon if this continues. In the meantime, vicodin 5/500 1 qid prn prin [*sic*] #120 w no refills.

Dr. Kingsbury's medical assistant responded to Dr. Kingsbury's questions later that day as follows: "I spoke with pt, he states they are going out of town for the next couple weeks. He wanted to make sure he had enough to get him by during his vacation."

43. According to the CURES report, 120 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on October 17, 2012.

44. After the patient's September 24, 2012, and October 17, 2012, phone requests, Dr. Kingsbury did not see the patient in person until March 6, 2013. In the meantime, Dr. Kingsbury continued to grant the patient's phone requests for medication refills as follows:

- On November 5, 2012, the patient called again seeking refills. The message given to Dr. Kingsbury that day said: "Pt lost his luggage in the Rome airport which had all his medications, he needs a refill of 3 medications: Naproxen 500 MG Tablet, Atacand 32 MG Tablet, Hydrocodon [*sic*] 500mg. He will be reducing his intake of hydrocodone this week." Dr. Kingsbury approved the request, including "vicodin 5/500 1 qid prn #120 w 1 refill." According to the CURES report, 120 Vicodin tablets were dispensed to the patient on November 5, 2012.

- On November 5, 2012, Dr. Kingsbury's medical assistant also scheduled the patient to see Dr. Kingsbury in the office on November 9, 2012; there was no record that the patient was seen on November 9, 2012.

- On November 29, 2012, the patient requested a refill of Xanax for insomnia. Dr. Kingsbury authorized #30 of Xanax 0.5 mg, with three refills. According to the CURES report 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on November 29, 2012.

- On December 18, 2012, Dr. Kingsbury was given the following message: "Pt had intestinal problems for the past week and threw up on his bottle of Xanax. He had to toss 5 of his pills. The pharmacy will not do an early refill unless we can authorize it 5 days early please advise." Dr. Kingsbury authorized the early refill. According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on December 18, 2012.

- On January 3, 2013, Dr. Kingsbury was given the following message: "Pt would like an rx for hydrocodone he pulled his lower back this afternoon." Dr. Kingsbury's response was "vicodin 1 qid prn pain #60; no refills." According to CURES, the prescription for 60 Vicodin tablets, prescribed by Dr. Kingsbury, was filled on January 3, 2013.

- According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed on January 11, 2013, and again on February 3, 2013.

- On February 12, 2013, Dr. Kingsbury received the following message: "I scheduled an appt for the pt to be seen today, he is requesting pain medication for his back. He called to cancel because he feels it's an unecessary [*sic*] hassle to come in on his day off. Pt states his back pain is from a genetic back disorder. Please advise." Dr. Kingsbury authorized "vicodin 1 qid prn pain #120, 1 refill." Dr. Kingsbury also asked his

medical assistant, "I'm unclear on his genetic back disorder - please get the name of this disorder and document here, back to me." His medical assistant responded: "Congenital birth defect born with club foot. R leg is shorter than left. His spine is not centered in the pelvic arc. He says from time to time it goes out. He doesn't know the proper name or diagnosis." According to the CURES report, the patient filled the prescription for 120 Vicodin tablets, prescribed by Dr. Kingsbury, on February 13, 2013.

45. Dr. Kingsbury had a six month follow up appointment with the patient on March 6, 2013. The Progress Notes stated the following under HPI: The patient was "sleeping well," "doing well - working happily," "was in a goKart [*sic*] crash last week - feels he needs more narcotic," "reported birth defect in his back - born w club foot - so back is bad off/on through life," and "stress on the job - started 3 months ago." Under "Medication Review," after "Patient administrates medications as prescribed," it stated, "Yes." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

The Progress Notes for that visit also included a "Pain Screening" which provided:

> Patient has a complaint of acute or chronic pain: Yes,
> Location of pain: Back, Intensity of pain (scale of 0-10): 5,
> Treatment or medications used to manage pain: NSAIDs,
> Opioids, Level of relief that the pain treatment has provided:
> 75%, Pain has interfered with the following: Mood, Sleep,
> Enjoyment of Life,
> Plans/Goals/Treatment/Intervention/Follow up: See Plan.[13]

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[13] The "Plan" listed medications, including Vicodin, 5/500 MG, 1 tablet as needed every six hours.

The Progress Notes included the following as the medications the patient was taking: "Alprazolam 0.5 MG Tablet take 1 tablet by mouth at bedtime if needed for sleep" and "Vicodin 5-500 MG Tablet 1 tablet as needed Orally every 6 hrs."

Under "Assessment" was listed:

- LBP [Low back pain] -724.2 (Primary), his primary concern - episodic strains- discogenic dz- stable, treat w PT,[14] narcotics prn
- Drug dependence, combinations excluding opioid type drugs, continuous - 304.81, anxiety and insomnia treated w alprazolam and prn vicodin for pain - stable
- OPIOID DEPENDENCE-EPISOD - 304.02, vicodin/norco use on/off for many years - stable - no changes to vicodin prn and alprazolam for spasm[15]
- Chronic persistent hepatitis - 571.41, biopsy IHSI 2003 - chronic active Hep C - has seen GI in the past (Haynes) - no treatment thought adequate at the time, follow LFTs/Liver synthetic function - stable
- Hepatitis virus C infection - 070.41, chronically elevated ALT and AST, stable - minimize Tylenol products and other s [*sic*] which may irritate liver

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[14] "PT" is an abbreviation for physical therapy. There was no evidence presented regarding whether the patient ever received physical therapy.

[15] This was the first and only time "spasm" was listed as an indication for Xanax.

- Insomnia - 780.52, prn alprazolam/vicodin - stable - no changes

46. According to the CURES report, the patient received 30 alprazolam tablets, prescribed by Dr. Kingsbury, on March 5, 2013.

47. After the March 6, 2013, appointment, Dr. Kingsbury refilled the patient's prescriptions as follows:

- According to CURES, on March 12, 2013, the patient was dispensed 120 Vicodin tablets prescribed by Dr. Kingsbury.
- On April 2, 2013, the patient requested a refill of Vicodin. Dr. Kingsbury authorized "#120 x 1 refill." According to CURES, the patient filled this prescription on April 3, 2013.
- On April 8, 2013, the patient requested a refill of alprazolam. Dr. Kingsbury authorized "#30 w 4 refills." According to CURES, the patient filled this prescription on April 9, 2013.
- On April 22, 2013, Dr. Kingsbury received the following message: "Pt is requesting an early refill of his Hydrocodone. It was last filled on April 3, he is going out of the country on wednesday and will need it. Please advise." The same day the patient also requested a refill of alprazolam because he was going to be in "Vienna for a month." Dr. Kingsbury authorized Vicodin "#120 1 qid, 1 refill" and alprazolam "#30 no refills." According to CURES, the patient filled the prescriptions for 30 alprazolam and 120 Vicodin on April 23, 2013.

MAY 8, 2013, THROUGH JUNE 26, 2013

48. The patient's last appointment with Dr. Kingsbury was on May 8, 2013. The "Chief Complaints" at that appointment were "Suicidal thoughts/depression." The Progress Notes stated the following under HPI: "extremely depressed," "picking at his

face a little," "work going poorly and he quit his job last week, uses the vicodin for depression 'makes me happy,'" "his relationship is abusive and he is very unhappy in it," "OK w seeing a therapist," "OK w antidepressant," "30min face to face," "thoughts of suicide but no plan," "contracted for safety and said he would call me if he felt he may follow through, or go to ER." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

The following was written under "Assessment": "Major depressive disorder, recurrent episode severe, without mention of psychotic behavior - 296.33 (Primary)" and "OPIOID DEPENDENCE[16]-CONTIN[17] - 304.01, used for anxiety and depression on pt admission today will taper slowly - 8/day now, scheduled and not PRN 'panic.'"

Under "Plan" was written (bold emphasis in original):

> **1. Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior**
>
> Start Lexapro Tablet, 10 mg, 1 tablet, Orally, Once a day, 30 days, 30, Refills 3.
>
> Referral To: Psychiatry
>
> Reason: pt occasionally w thoughts of harming self - started on lexapro and xanax today.
>
> **2. Others**

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[16] Dr. Kingsbury explained that "dependence" meant the patient had a physical or psychological need to continue taking the medication and would suffer withdrawal when he stopped taking the medication.

[17] Dr. Kingsbury stated that "CONTIN" meant "continuing."

Continue Vicodin Tablet, 5-500 MG, 1 tablet as needed,
Orally, every 6 hrs.

49. According to CURES, 240 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on May 8, 2013. There was no record on CURES that the patient ever filled Dr. Kingsbury's Lexapro (escitalopram) prescription.[18]

50. During the subject interview, when Dr. Kingsbury was asked why he prescribed 240 Vicodin tablets on May 8, 2013, he responded, "I believed that his oral contract with me was satisfactory, and I believed that he would return in two weeks to see me." During the instant hearing, Dr. Kingsbury testified that 240 tablets were "'ridiculous' in the situation" and did "not seem rational." Dr. Kingsbury could not believe he actually prescribed that many, as it would have been twice the number he had previously been prescribing, but he did not have any records to show what he prescribed. Dr. Kingsbury was "baffled" by the number 240; he could not say he did not prescribe that amount, but he could not believe he did.

51. At the time of the May 8, 2013, appointment, a follow up appointment was scheduled for May 22, 2013. However, the patient did not show up for the May

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[18] During the hearing, Complainant's expert offered opinions regarding Dr. Kingsbury's prescription of Lexapro at the May 8, 2013, office visit. However, the accusation did not provide Dr. Kingsbury notice that his decision to prescribe that medication somehow subjected his certificate to discipline, and Complainant did not seek to amend the accusation. The existence of cause to discipline a licensee must necessarily track the specific allegations in the accusation. (See Gov. Code, § 11503, subd. (a), which requires the accusation to "set forth in ordinary and concise language the acts or omissions with which the Respondent is charged, to the end that the Respondent will be able to prepare his or her defense.") Therefore, only the charges alleged in the accusation are considered in this decision.

22, 2013, appointment. Dr. Kingsbury's office left messages for the patient that day and set another appointment for June 5, 2013.

52. On June 26, 2013, the Orange County Coroner's office contacted Dr. Kingsbury and notified him that the patient had been found dead of suspected suicide on May 20, 2013. Dr. Kingsbury wrote the following on the June 26, 2013, telephone encounter under "Action Taken": "[Patient] found dead 5/20, suspected suicide in Orange County, from OD. Empty pill bottles w my name found at scene. One bottle (unk med) w Dr. Tadros' [*sic*] name. Records reviewed in detail. [Patient] had apparently seen Dr. Tadros of psychiatry one time prior to death." According to the Coroner's report, the patient's cause of death was "[a]cute citalopram, hydrocodone, alprazolam and clonazepam intoxication."

Dr. Kingsbury's Written Summaries

53. As requested by Consumer Services Analyst Erika Calderon, Dr. Kingsbury prepared a written summary, dated April 5, 2018, which appeared to track the medical records. At the end of the summary, he described his reaction to the patient's death, reflected upon his treatment of the patient, and listed changes he had made in his practice as a result of what happened:

> The death of Mister [Patient] was quite a shock to me and my staff. He had been a valued client of my medical practice for 10 years. I knew he was a troubled soul and had a lot of anxiety and depression in addition to his pain and addiction. Though it is not always reflected in the record, we often spoke of his personal issues and potential solutions, knowing the drug abuse made it more difficult to treat the anxiety and depression. As I look back through the records I can certainly see areas where I could have intervened in a more beneficial way for him. Mr. [Patient] needed more help for his problems. As a consequence of his difficult course and eventual demise we made many

> changes in the way we prescribed narcotics alone and in combination with benzodiazepines. I maintain a tremendous amount of respect for hydrocodone's addictive potential. Shortly after his death we created our Narcotic Medication Agreement which I have included with the records for your review. We also developed an Opioid Analgesic Medication Information handout so that clients can better understand the use of narcotics and their potential side effects. It also became state law that we could no longer prescribe refills for hydrocodone containing narcotics, which added tremendous safety value to our patients requiring opioids. Refills could no longer be filled by patients independent of their physicians writing a new prescription. Pharmacies have also become far more helpful by not refilling restricted medications early without a discussion with me first. We have since made it a requirement for all patients on narcotics to see me every other prescription in the office without exception. They don't like it but they are far safer because of it.

54. Dr. Kingsbury wrote another summary, dated November 20, 2018 (the same day as his subject interview). That summary went into detail regarding why Dr. Kingsbury believed he succumbed to the patient's requests for medication and Dr. Kingsbury's regrets for doing so. Dr. Kingsbury wrote (emphasis in original):

> The medical records of Mr. [Patient] reflect that I prescribed him hydrocodone and alprazolam in the course of managing his medical problems over the course of 10 years. The records also reflect a variety of successful attempts on his part to manipulate me into providing him more of these medications than originally intended. His persistence wore me down and I prescribed his medications

in a manner I regret. In review of the records, I can see I felt I had control when clearly I did not. He was charismatic, intelligent and well spoken, and I gave him the benefit of the doubt too often.

I understand that my documentation could certainly have been better - I could have clarified my thought process and recorded my prescriptions and dates more completely . . . .

I believe the record demonstrates that I cared for this man and his well being and function were my primary concerns. I made attempts to limit and wean the habit-forming medications, utilized antidepressants and anti-anxiety measures and discussed this with him in the office and over the phone. We discussed counseling, physical therapy and other specialties several times, but it's not evident in my documentation until May 2013.

Initially I was treating his back pain - I reviewed his cervical spine disease documented on xray, have been trained to know that low back pain is a common condition and doesn't require imaging to treat briefly with Tylenol, NSAIDs and potentially opiates. I was aware of his history of IVDU and opiate dependence and understood that, once conditioned to opiates, an addicts' [*sic*] pain pathways are forever altered, and responses to the usual doses of narcotics will be suboptimal. This can lead to higher need for narcotics when faced with pain and sobriety, and I felt this was the case with him. When his behavior turned suspicious and manipulative, I limited prescriptions and attempted weaning, but maintained his prescriptions to prevent

withdrawals and preserve his best function. Once again, I felt I had things under control.

[¶] . . . [¶]

I have extensive experience with a broad spectrum of acute and chronic pain in the hospital as an attending physician on the teaching faculty, and in my own clinic. I am experienced with the medications used to treat and maximize function. In my work in the Behavioral Health Unit at Scripps Mercy Hospital I see all kinds of psychiatric illness; anxiety, depression, personality disorders, alcoholism, drug abuse and addiction, and pain medication seeking behavior as well. I have always been drawn to care for these individuals, and have felt I had something to offer them.

Often a person who has chronic pain, a personality disorder, anxiety and depression can be seen as a time-consuming, difficult patient, where the emotional cost and the amount of time necessary to find physicians who will give them the time they need, and so, often I feel obliged to have this be me. Often I have made referrals to pain management physicians, and when my patients don't respond to procedural interventions they wind up back with me. I maintain these clients because I feel I have to; it's my obligation to them.

[¶] . . . [¶]

Chronic pain and opiate dependence remain a small part of my current medical practice. These patients are the most emotionally challenging for me, as my level of suspicion for

> abuse must always remain high, and drug dependence is always a part of the equation. They require an individualized approach.
>
> I did not demonstrate an ability to set limits and enforce rules consistently with Mr. [Patient].

Expert Opinion Testimony

55. Complainant called Robert M. Franklin, M.D., as an expert witness and his 32-page December 2, 2018, report was received as evidence without objection. Dr. Franklin's assignment in this case was to review the patient care Dr. Kingsbury provided, assess whether Dr. Kingsbury departed from the standard of care, and, if so, determine whether the departures were extreme or simple departures. Dr. Franklin reviewed all the medical records, the CURES report, Dr. Kingsbury's written summaries, and Dr. Kingsbury's subject interview testimony in order to render his opinions.

56. At times during his testimony as well as in his report, Dr. Franklin seemed to take on the role of an advocate and was quite zealous in the manner in which he articulated his opinions, including employing unnecessarily inflammatory and argumentative language.[19] He also admitted on cross-examination that he purposely

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[19] For example, he described his own reactions to certain facts using words such as "flabbergasted" and "stunned"; he described some departures from the standard of care as "deadly," "lethal," fatal," and "homicidal"; and he blamed Dr. Kingsbury for the patient's decision to commit suicide based on a Blackbox warning for Lexapro which only applied to young adults under age 24, even though the patient was 66 at the time of his death and the same warning contained language indicating that there was a reduction in risk of suicide in adults aged 65 and older. Such hyperbole was wholly unnecessary and contrary to Dr. Franklin's assignment to provide dispassionate expert opinions.

included language in his report to influence the level of discipline, even though he was cognizant that analyzing the appropriate level of discipline was outside the scope of his assignment and should be left to the trier of fact. Therefore, while evaluating Dr. Franklin's opinions it was necessary to set aside Dr. Franklin's at times overzealous and inflammatory language, and no consideration was given to his statements geared toward a determination of the appropriate level of discipline. Additionally, Dr. Franklin opined that certain statements made by Dr. Kingsbury during the 2018 subject interview were themselves separate departures from the standard of care. Dr. Franklin interpreted those statements to mean that Dr. Kingsbury failed to accept responsibility in 2018 for what happened in 2012 and 2013, and he opined that the *sole* act of making such statements constituted departures from the standard of care. Such opinions were excluded at the hearing, and to the extent such opinions were espoused in Dr. Franklin's report, they were not considered when rendering this decision.[20]

DR. FRANKLIN'S EDUCATION AND EXPERIENCE

57. Dr. Franklin is licensed to practice medicine in California and is a Diplomate of the American Board of Family Medicine. He obtained his Bachelor of Arts Degree in Zoology from the University of California at Berkeley in 1986 and his Medical Degree from George Washington University School of Medicine in 1990. He

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[20] Although the Business and Professions Code authorizes imposing discipline on a physician for departing from the standard of care during the treatment and care of a patient, it does not authorize imposing discipline *solely* for Respondent's later statements. While such statements may be evidence of a departure during the treatment and care, and/or may be weighed by the trier of fact in determining the appropriate level of discipline, there was no authority cited to warrant imposing discipline for making the statements. Furthermore, assessing whether Dr. Kingsbury accepted responsibility for his conduct was outside the scope of Dr. Franklin's role as an expert witness.

completed his three-year residency at the University of California at San Francisco in Family Practice in 1993. Dr. Franklin then worked as a part-time family physician at Southeast Health Center in San Francisco from June 1993 to December 1994 and as an emergency department physician at St. Luke's Hospital in San Francisco from December 1991 to April 1999. He has worked as a family physician at Southeast Health Center in San Francisco since January 1995 and as an emergency department physician at Kaiser Hospital in South San Francisco since September 1997. Dr. Franklin has treated patients with liver damage, opioid dependence, and addiction to alcohol and drugs.

58. Dr. Franklin has served as a medical consultant reviewing cases for the Medical Board of California since December 2003 and as an expert witness, through American Medical Forensic Specialists, since 2009. He has been an expert witness for complainant in approximately 50 cases, and he has provided expert opinion testimony in about a dozen administrative disciplinary hearings. According to Dr. Franklin, when he has reviewed cases as a consultant for the Board, he has found no departures from the standard of care in the majority of the cases he has reviewed.

SUBSTANCE ABUSE AND ABERRANT DRUG BEHAVIOR

59. Dr. Franklin defined substance abuse as misuse of drugs. Intravenous drug use is the "most severe and dangerous" and alcohol abuse is a common form of substance abuse in our society. Prescribing controlled substances to someone with a substance abuse disorder is one of the most challenging aspects of an office-based medical practice. A person who is actively abusing drugs cannot control their consumption. Someone with a history of opiate use disorder has a higher risk of relapse, and if a person has abused one substance, it is more likely that person will abuse another substance.

60. In Dr. Franklin's report, he explained:

> Before we delve into the morass of departures from the standard of practice that was Dr. Kingsbury's management

> of Mr. [Patient's] chronic pain and substance use disorder, it is important to highlight the term aberrant drug behavior, defined in the standard above, as it applies to Mr. [Patient's] case. Addiction is difficult to precisely define. Recall that Mr. [Patient] defined his use of Vicodin as an addiction in November 2011. It is simplest to regard addiction as a combination of dependence, tolerance, craving and withdrawal upon discontinuation of, in this case, Vicodin. Misuse of course, is a much more straightforward word. Every time Mr. [Patient] took more Vicodin or more Xanax than Dr. Kingsbury instructed him to take, he misused those medications. Aberrant drug behavior in Mr. [Patient's] case appears to be limited to misuse and addiction.[21]

STANDARD OF CARE

61. Dr. Franklin generally defined the standard of care as "what a doctor should do in a given clinical situation." He also agreed during cross-examination that the standard of care is the level of care that would ordinarily be exercised by a doctor in the community under similar circumstances. Dr. Franklin used the terms "standard of care" and "standard of practice" interchangeably to refer to the standard of care. According to Dr. Franklin's direct examination testimony, the standard of care applicable to Dr. Kingsbury's treatment of the patient at issue in this case included the Board's Pain Treatment Guidelines, but the standard of care required more than was stated in those guidelines.

62. Dr. Franklin defined extreme and simple departures from the standard of care as follows: an "extreme" departure would be something so far from the standard

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[21] The report included a footnote here, which stated: "Diversion is discussed in the interview. There is no evidence that Mr. [Patient] diverted his medication or received diverted medication, though that may have happened."

of care that "no doctor should do it" and it could cause "direct damage" to the patient, which "no doctor should do." According to Dr. Franklin, a "simple departure" would be something "not as bad as" an extreme departure.

63. According to Dr. Franklin, the time period at issue for purposes of assessing the standard of care in this matter was from the first time Dr. Kingsbury prescribed opioids to the patient in 2009 through 2013.[22] According to Dr. Franklin, during that time, the standard of care generally required Dr. Kingsbury to take a history, examine the patient, order required studies and labs, make reasonable assessments based on the data, develop a plan of treatment, obtain client consent, treat the patient's condition as planned, monitor the outcome, and document the treatment and care.

64. Dr. Franklin explained that the standard regarding the use of opioids to treat pain has evolved over the years. From 1990 to 2010, the standard of care required aggressive treatment of pain and there was no ceiling on the dosage of pain medications that could be prescribed. Pain was considered the "fifth vital sign," and physicians were expected to use whatever was necessary to treat pain, including opioids. From 2010 through 2012, the medical community standard started shifting away from using whatever was necessary to treat pain because it was becoming apparent that it was dangerous to prescribe high doses of opioids. By 2012 and/or 2013, "most of us backed away" from treating pain with opioids. By 2016, the Center for Disease Control declared that it was no longer considered safe to prescribe high

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[22] Although Dr. Franklin rendered opinions regarding whether Dr. Kingsbury departed from the standard of care before January 2012, those opinions were not considered in rendering this decision because Complainant was barred from seeking to discipline Dr. Kingsbury for conduct that occurred more than seven years before the accusation was filled on January 3, 2019.

doses of more than 50 morphine equivalents per day (1 mg equaled 1 morphine equivalent dose).[23]

65. According to Dr. Franklin, the standard of care has not changed that much. It required Dr. Kingsbury to "do it right"; what was "right" has changed. Dr. Franklin considered the Board's Pain Treatment Guidelines as the "floor" of what physicians should have been doing if they were "doing everything okay." The Pain Treatment Guidelines were created "to help doctors comply with the standard of care." But the Pain Treatment Guidelines did not include everything needed to comply with the standard of care.

66. In this case, Dr. Franklin explained that the standard of care required Dr. Kingsbury to do the following when prescribing controlled substances:

- Conduct an assessment of the patient's pain, including an examination and an "assessment of what was wrong."
- Develop a treatment plan that had goals/objectives.
- Document the medical indication for treatment of pain with opioids, including the cause of the pain and the reasons opioids were included as part of the treatment. The physician should not let the "indication morph into different things."
- Obtain informed consent from the client before proceeding with the plan. The informed consent required would involve a dynamic process between the patient and physician and could be very simple. Informed consent should include a reasonably complete discussion of relevant

[23] This was not an issue in this case, as the daily doses of opioids Dr. Kingsbury prescribed the patient were at 20 morphine equivalents or less. Furthermore, according to Dr. Franklin, the amount consumed by the patient when he took more Vicodin than Dr. Kingsbury intended never exceeded 50 morphine equivalents per day.

risks and benefits, and it could be implied. Written informed consent was not required for the prescription of controlled substances.

- Prescribe a limited amount of medication, be acutely aware of the drugs prescribed, and if prescribing to an addict, be "really careful." Physicians should not "negotiate" with an addict; the physician must maintain control of the patient's access to controlled substances.

- Limit the dosage of acetaminophen to no more than 4,000 mg (or 4g) per day for any patient, and no more than 2,000 mg (or 2 g) for a patient with liver disease, such as hepatitis C.

- Conduct periodic review of how the patient was doing with the treatment, including assessing whether the treatment was working and noting any red flags, such as early refills, past addiction, and/or withdrawal symptoms. A physician may want to alter the course of treatment and consider alternative treatments.

- Diligently look for signs of abuse and aberrant drug use. Every time the doctor saw the patient, it was important to consider if the drug was being used to "good effect."

- Respond in an organized way if abuse or misuse was detected. If a patient was obtaining early refills and the pharmacy notified the doctor, then the doctor would need to act upon that. When aberrant drug behavior was detected, the physician needed to stop it. There was "no wiggle room." The easiest way to stop would be to stop prescribing, but that may not be the best thing to do. A physician could start seeing a patient weekly and involve the pharmacist and the family. A physician could taper the use of the medication by reducing the dose. Typically, a "rapid" taper would involve reducing the dose by 10 percent per day, but it could be per month.

- Consultation with others if the physician was not capable of rendering the care. In the treatment of pain, consultation could be a series of emails with a pain group, referral to specialists, and/or calling a specialist.

- Additionally, the standard of care precluded office-based use of opioids to treat opioid addiction.

- Accurately document everything in the medical records, because "if it was not in the chart it did not happen." The medical records needed to be complete and accurate so they would show what was being done and why. Every prescription must be clearly documented, including "what it was for" and "how long it was for." It was the community standard to write every prescription in the progress notes with a next refill date. Then the physician could see if the patient was seeking early refills. The standard of care required the physician to have control over the drugs being prescribed and it was not possible to do that if the prescriptions were not adequately documented. It was also possible to clearly write "quantity sufficient until" a specific date on prescriptions so that the pharmacist would know not to give a refill before that date.[24]

- Sign and date the medical documentation within a reasonable time.

DEPARTURES FROM THE STANDARD OF CARE

67. Dr. Franklin determined that Dr. Kingsbury engaged in numerous extreme departures from the standard of care; several simple departures from the standard of care; that he demonstrated a lack of knowledge during his treatment and

[24] Because the prescriptions were not offered as evidence and the progress notes did not state such language was used, there was no evidence that Dr. Kingsbury used such language on the prescriptions at issue here.

care of the patient; and that his medical record keeping was deficient in multiple respects.

Extreme Departures from the Standard of Care

68. Dr. Franklin opined that Dr. Kingsbury's care and treatment of the patient amounted to several extreme departures from the standard of care. His hearing testimony tracked his report, which provided[25]:

- "Dr. Kingsbury's management of Mr. [Patient's] pain, anxiety, depression, and substance use disorder" was a series of extreme departures, "culminating in the prescription of 480 tablets of Vicodin 5/500 in the 35 days up to and including the last visit with the patient. Such a massive over-prescription of controlled medication to a man with known liver disease, opioid use disorder, and suicidal ideation was an extreme departure from the standard of practice."

- Dr. Kingsbury was over-prescribing opioid to the patient "at least as early as 12/31/10. Every prescription for Vicodin that follows that date represents a separate extreme departure from the standard of practice."

- Dr. Kingsbury's failure to "recognize each red flag for aberrant drug behavior" was a series of extreme departures from the standard of care, and "[e]very early prescription, each excessive prescription, represented such a red flag."

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[25] Although Complainant argued that there were over 100 such departures, it is worth noting that Dr. Franklin's list of extreme departures overlapped, was repetitive, and included departures outside the statute of limitations because they occurred more than seven years before the filing of the accusation. While the nature and extent of the departures from the standard of care were important, the specific number of departures was not determinative of the conclusions reached in this decision.

- Dr. Kingsbury's failure "to take decisive action to eliminate Mr. [Patient's] aberrant drug behavior" was a series of extreme departures from the standard of care.

- "It was an extreme departure from the standard of practice to fail to immediately taper and discontinue Vicodin on 11/21/11 when he described himself as addicted to Vicodin. Every prescription for a controlled [*sic*] issued on or after 11/21/11 represents a separate extreme departure from the standard of practice, because none of those prescriptions were issued in the course of a rigorously structured taper."

- At the time of the last, May 8, 2013, office visit, Dr. Kingsbury's "apparent belief that Mr. [Patient] was reducing his consumption of Vicodin at a time when Dr. Kingsbury prescribed 480 tablets in 35 days" was an extreme departure from the standard of care.

- Dr. Kingsbury's failure "to document the detailed historical and physical findings that supported treatment of Mr. [Patient] with opioids and benzodiazepines" was an extreme departure from the standard of care.

- Dr. Kingsbury's failure "to document an analysis of the impact on Mr. [Patient's] quality of life of [*sic*] his chronic pain" was an extreme departure from the standard of care.

- "Because of Mr. [Patient's] known history of prior intravenous drug abuse, it was an extreme departure from the standard of practice to undertake to treat Mr. [Patient's] chronic pain with opioid medication without specifically documenting how that treatment was to be done while simultaneously preventing his return to drug addiction."

- "It was an extreme departure from the standard of practice to fail to document a recognized indication for the use of Vicodin in the treatment of Mr. [Patient]. It was a series of extreme departures from the standard

of practice to allow the record to be unclear as to whether Vicodin was being used to control pain or to control cough. If Vicodin was indeed being used to control cough, it is and [*sic*] extreme departure from the standard of practice that there is no documentation of why it was used for that 'off label' indication."

- "It was an extreme departure from the standard of practice to fail to perform and carefully document informed consent prior to beginning treatment with opioids in a formerly drug addicted patient."

- "It was an extreme departure from the standard of practice to fail to carefully document a specific treatment plan with measurable benchmarks for the use of opioid medication. It was an extreme departure from the standard of practice to fail to carefully document the non-opioid pain treatment plan in parallel with the opioid treatment plan."

- "It was a series of extreme departures from the standard of practice to fail to document formal periodic reviews of the safety and efficacy of the treatment of Mr. [Patient] with opioid medication."

- "It was a series of extreme departures from the standard of practice for Dr. Kingsbury not to diligently search out evidence of aberrant drug behavior such as early refills and overuse of controlled medication."

- Once Dr. Kingsbury became aware of the patient's "aberrant drug behavior, self-acknowledged addiction and a pattern of medication overuse," it was an extreme departure from the standard of care to fail to "formulate and document in the medical record a rigorous plan to control that behavior."

- "Dr. Kingsbury's failure to document the fact that in early 2012 he thought he was being manipulated by Mr. [Patient] was an extreme departure from the standard of practice."

- Dr. Kingsbury's failure to refer the patient for treatment of his addiction was an extreme departure from the standard of care.

- "It was a separate departure from the standard of practice to prescribe 240 tablets of Vicodin to Mr. [Patient] rendering the likelihood of a taper to nothing, on the very day when the taper was supposedly instituted."

- "Dr. Kingsbury's failure to take any of the recognized steps that a rational physician would take to ensure that a patient with substance use disorder would safely taper his opioid use is a series of extreme departures from the standard of practice."

- "Dr. Kingsbury's decision to resume prescription of opioids to Mr. [Patient] on 9/25/12 was a life threatening extreme departure from the standard of practice that directly contributed to Mr. [Patient's] renewed abuse of opioids."

- "It was a series of life threatening extreme departures from the standard of practice to overdose Mr. [Patient] with acetaminophen" in 2012 and 2013. Dr. Franklin calculated, based on the CURES information showing the dates and amounts of Vicodin dispensed to the patient, that from January 2012 through May 2013, the patient, who suffered from liver disease, was routinely consuming more than 2,000 mg of acetaminophen.

- "It was an extreme departure from the standard of practice to fail to document a rationale for the prescription of Ambien in the medical record prior to first prescribing it on 1/24/12."

- "It was a separate extreme departure from the standard of practice to fail to include in that documentation a detailed discussion of why and how it

was safe to simultaneously prescribe benzodiazepines[26] and opioids to a patient with opioid use disorder."

- With respect to the prescribing of Ambien and Xanax, "[i]t was a series of separate extreme departures from the standard of practice to fail to document the rationale for that treatment plan from 1/24/12 through the final visit in 2013."

- It was a series of "extreme departures from the standard of practice to allow Mr. [Patient] to have access to more than the intended amount of Ambien and Xanax."

- "It was a series of extreme departures from the standard of practice to allow the rationale for the prescription of benzodiazepines to shift and change in the record without a detailed discussion of why that was happening."

- It was an extreme departure from the standard of care "for Dr. Kingsbury to prescribe 240 tablets of Vicodin to Mr. [Patient] on 5/8/13 when Mr. [Patient] reported suicidal ideation" even though Dr. Kingsbury thought his oral contract with the patient was "satisfactory." "Providing a suicidal patient with a lethal dose of medication, contract or no contract, is . . . an extreme departure from the standard of practice."

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[26] Although Dr. Franklin testified that Ambien is not a benzodiazepine, but a benzodiazepine analog, he grouped Ambien and Xanax, which is a benzodiazepine, together as "benzodiazepines" when rendering his opinions.

- "It was a series of extreme departures from the standard of practice to lock" the progress notes "in 2018 without adding an addendum to the record indicating what was being done and why."[27]

- "It was a series of extreme departures from the standard of practice to prescribe controlled substances for more than 30-day intervals."[28]

- "Dr. Kingsbury's failure to recognize that Mr. [Patient's] primary diagnosis was substance use disorder, complicated by various comorbidities" was an extreme departure from the standard of care.

Simple Departures from the Standard of Care

69. According to Dr. Franklin's testimony, which tracked the opinions in his report, Dr. Kingsbury engaged in the following simple departures from the standard of care:

- "It was a series of simple departures from the standard of practice to fail to document in the medical record the exact quantity and number of refills issued for controlled medications."

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[27] Dr. Franklin also opined that if the records were "substantively altered in 2018 before being locked, that was an extreme departure from the standard of practice." However, the accusation did not allege the records were altered and there was no evidence presented that the records were altered. Therefore, that speculative opinion, regarding something which was not alleged in the accusation, was not considered in rendering this decision

[28] There was no evidence presented that Dr. Kingsbury prescribed controlled substances for more than 30-day intervals; Dr. Franklin was clear in his testimony that refills were permitted for the medications prescribed during the timeframe in question.

- Dr. Kingsbury's "failure to 'lock', to electronically sign, multiple progress notes in a timely fashion" was a series of simple departures from the standard of care.

Lack of Knowledge/Incompetence

70. Dr. Franklin opined that Dr. Kingsbury's decision to continue treating the patient with opioids, with knowledge of the patient's history of drug abuse, and after becoming aware that the patient was misusing the medications, showed Dr. Kingsbury lacked the knowledge to capably care for this patient. In his report, Dr. Franklin wrote:

> In a discussion during the interview of his failure to refer Mr. [Patient] for treatment of his opioid addiction, Dr. Kingsbury states: "I honestly felt that I was well-prepared to take care of this man. I have a lot of diverse training in this area. I have a lot of experience with psychiatric patients of all kinds of pain, acute and chronic. I felt like I was an appropriate physician for him." [Fn. Omitted.] . . . The objective record in this case demonstrates that Dr. Kingsbury was not only incapable of treating Mr. [Patient] for his opioid addiction, but was incapable even of limiting the amount of opioids that he personally prescribed to this opioid addicted man. The record therefore proves that Dr. Kingsbury was anything but an "appropriate physician for him." Dr. Kingsbury not only failed to treat Mr. [Patient's] addiction in any way, but he provided the means for Mr. [Patient] to remain addicted. The standard of care does not require an office-based primary care physician to treat addiction. But it does require that physician to refer drug addicted patients for addiction treatment. More importantly, the standard of care specifically requires physicians not to provide chronic opioid medication to opioid addicts, except in the most

> unusual circumstances, none of which even remotely apply to Mr. [Patient]. While an opioid-addicted patient dying of a painful cancer might reasonably be treated with opioid pain medication, Mr. [Patient] was not dying of a painful condition. He was injuring himself with addiction to opioid medications, prescribed by Dr. Kingsbury variously for cough and ill-defined pain. . . .

71. Dr. Franklin concluded that Dr. Kingsbury's actions when, and continuing after, he initiated the plan to taper the patient from his Vicodin use beginning November 21, 2011, demonstrated a lack of knowledge in a number of respects. The manner in which Dr. Kingsbury instituted the taper, including prescribing 240 tablets of Vicodin, showed a "lack of knowledge of substance abuse disorder." Dr. Franklin also opined that Dr. Kingsbury's note on October 17, 2012, asking "' WHY he is using so many Vicodin'" was "evidence of inexplicable lack of knowledge" because Dr. Kingsbury was "asking why drug addicts abuse the drugs to which they are addicted. The level of lack of knowledge represented by that question is hard to comprehend."

72. Similarly, Dr. Franklin opined that Dr. Kingsbury's feeling that "he 'had things under control' at the 5/8/13, the final visit . . . represents a stunning lack of knowledge," and his "apparent belief that Mr. [Patient] was reducing his consumption of Vicodin at a time when Dr. Kingsbury prescribed 480 tablets in 35 days" was an extreme departure from the standard of care. Dr. Franklin noted in his report that "[t]he combination of these extreme departures from the standard of care and appalling lack of knowledge casts doubt on Dr. Kingsbury's ability to learn how to practice medicine safely, as it relates to the prescription of controlled substances." "Dr. Kingsbury's thought that 'his oral contract with me was satisfactory'" was "representative of profound, deadly lack of knowledge."

73. Dr. Franklin testified, and wrote in his report, that Dr. Kingsbury's "failure to recognize" that the patient's "primary diagnosis was substance use disorder, complicated by various comorbidities" was both an extreme departure from the

standard of care and represented a lack of knowledge. "His belief that he was well-prepared to take care of Mr. [Patient] represents lack of knowledge." The fact that Dr. Kingsbury believed "he limited Mr. [Patient's access to Vicodin in the face of the documented fact that he overprescribed Vicodin from 9/25/2012 forward," represented a lack of knowledge because Dr. Kingsbury did "not know what it means to limit access. The fact that he failed to recognize that opioid use disorder is a chronic problem that contraindicates the chronic outpatient prescription of opioid medication is reflective of" lack of knowledge.

74. Dr. Franklin testified and wrote in his report that the fact that Dr. Kingsbury was surprised that pharmacists refilled prescriptions sooner than in 30-day intervals demonstrated a "lack of knowledge" that pharmacists may "refill prescriptions at earlier than 30-day intervals unless there is a specific written order not to do so." During his hearing testimony, Dr. Franklin went so far as to state that "everyone" in the medical community knew during the 2012 and 2013 timeframe that pharmacists were inappropriately dispensing refills earlier than they should.[29]

Discrepancies in the Medical Records

75. During Dr. Franklin's testimony and in his report, he listed Dr. Kingsbury's failures to document important information in the medical records of the patient as required by the standard of care:

- An adequate history of the nature of the patient's pain and its effect on the patient's quality of life was not well documented. Dr. Kingsbury did

[29] Although Dr. Kingsbury may have made a point that physicians should have been able to rely on pharmacists not to dispense early refills, the fact that the pharmacist notified him on November 21, 2011, that this patient had been dispensed monthly supplies of Vicodin in two to three-week intervals seriously undercut that argument and showed that Dr. Kingsbury was on notice that pharmacists had given this patient early refills.

not document an analysis of the pain and its effect on quality of life, which would usually be "framed in terms of what the patient is unable to do because of pain."

- The patient's psychiatric complaints were not well documented "particularly in early 2012 when treatment with zolpidem was undertaken."

- Although a history of substance abuse was clearly documented, "critically absent, from the record is a discussion of precisely how Dr. Kingsbury planned to prescribe this former intravenous drug addict controlled medication in a safe and effective manner, without allowing him to relapse into addiction."

- "Dr. Kingsbury did not document a recognized indication for treatment with opioid medications."

- "[T]he medical record does not include a discussion of exactly what pain is under treatment and exactly how that pain is being evaluated."

- Dr. Kingsbury's documentation did not describe "for what, exactly, Vicodin is prescribed. The documented medical history includes 'Cough - responds to Vicodin'. Yet of course Vicodin is not indicated as a treatment for chronic cough."

- "The multiple and changing justifications offered for treatment documented in the medical record reflect the absence of a rational assessment of Mr. [Patient's] pain."

- Informed consent to treat the patient with opioid medication was not documented.

- "Specific treatment goals are not documented" and "[a]lternative treatment modalities are not well-documented."

- There was "[n]o careful documentation of the effectiveness or safety of ongoing treatment of Mr. [Patient] with opioid medication."
- "[I]t was not possible from the record to determine the exact quantity and timing of controlled substances."
- The medical record "was not managed appropriately: multiple progress notes were not electronically signed until April 2018."
- There was no "clear indication for the prescription of benzodiazepines to Mr. [Patient]. Through the course of the chart, the indication varies. Sometimes it is insomnia. Sometimes it is anxiety. At one visit it is muscle spasm."
- Although the CURES reports showed that Ambien was prescribed beginning in January 2012, it was not mentioned in Dr. Kingsbury's medical records until the patient's request for a refill was noted in a telephone encounter record, dated March 14, 2012.
- The progress notes stated the patient was sleeping well, which contradicted the indication for medication to help with insomnia.
- "There is no discussion at all in the medical record of the dangers of prescribing the commonly lethal combination of opioids and benzodiazepines to a patient suffering from opioid use disorder."

Dr. Kingsbury's Hearing Testimony

76. During his hearing testimony, Dr. Kingsbury did not deny that he failed to appropriately treat and care of the patient or that his record keeping was inadequate. He acknowledged responsibility for his conduct and expressed his shame, humiliation, and remorse. His testimony was sincere and direct.

77. Dr. Kingsbury admitted that by 2011 he knew the patient was misusing his medications and manipulating him. When Dr. Kingsbury was notified by the pharmacy of the early refills on November 21, 2011, and based on what the patient told him the same day, Dr. Kingsbury was "very concerned about it," and "it was clear" that the patient "was not using" the medications "as intended." Dr. Kingsbury then knew the patient needed to slow down and needed to come off the Vicodin slowly. So, Dr. Kingsbury tried to carefully reduce the patient's consumption at that time. Dr. Kingsbury also gave the patient a "strict warning" on December 21, 2011, that if he went above 4 g per day of acetaminophen it would damage his liver and he needed to bring it down. After the patient reported on January 23, 2012, that he was down to 3 Vicodin per day, Dr. Kingsbury thought things were under control as of February or March of 2012. When Dr. Kingsbury was asked whether he ever considered prescribing a pain medication that did not contain acetaminophen, he could not recall if he did, and then stated that he "definitely should have."

78. Dr. Kingsbury acknowledged that there were red flags of aberrant drug use which included the patient's claims that he had lost medications, vomited on medications, needed extra medication because he would be out of the country, lost luggage containing medication, and needed medication for a club foot and due to a Go Kart accident. Dr. Kingsbury stated that "in retrospect" he realized these were "all lame excuses to get pills." The patient's girlfriend also spoke with Dr. Kingsbury twice about her concerns. Looking back, Dr. Kingsbury recognized that the patient was not being "genuine" with him.

79. Dr. Kingsbury described his relationship with the patient as "push me pull me." Dr. Kingsbury sometimes felt "uncomfortable" with the patient, who he described as charming, well-spoken, and a decent communicator. Although Dr. Kingsbury may have thought at the time that he had some control, he acknowledged during his hearing testimony that "obviously" he was "not offering any resistance to the requests." Dr. Kingsbury realized he was "too easily manipulated" and he "didn't have the proper perspective." He did not have "check points" to "neutralize" his own reaction to the patient. According to Dr. Kingsbury, "mostly," the patient was able to "get under" his

"skin." Something "appealed" to him about the patient, as Dr. Kingsbury has a "soft spot for troubled souls." Often such patients are "difficult to deal with," "lots of doctors don't want to deal with them at all," and they are "difficult to control." Dr. Kingsbury acknowledged that he was aware the patient was not using the Vicodin for pain. At the time, Dr. Kingsbury felt that, with his experience with the Behavioral Health Unit, he was a "good fit" to treat this patient. But at the time of the hearing, Dr. Kingsbury no longer felt that way. Dr. Kingsbury conceded that he was "unable to set limits" with the patient, and he "wished" he had referred the patient to a specialist earlier.

80. The purpose of tapering the patient off Vicodin during 2013 was to help the patient avoid withdrawal symptoms because the patient had previously suffered severe withdrawal symptoms. The patient expressed the desire to get off the narcotics, and Dr. Kingsbury "did not want him to experience a lot of negativity." As of May 8, 2013, Dr. Kingsbury "needed to act" and to "avoid" the patient acting on his suicidal thoughts.

81. Dr. Kingsbury also testified that he had "overstressed the importance of withdrawal response." He "overemphasized the risk of withdrawal" and was "nervous" about cutting the patient completely off the medication. Looking back, it was not a reasonable way to handle it, making Dr. Kingsbury's current situation "quite humiliating" and "embarrassing." Dr. Kingsbury stated that he did not "know how this happened"; he did not have the information available, because of the way his medical records were written, "to even figure out" why he handled the situation the way he did. He "let the patient manipulate" him.

82. During Dr. Kingsbury's training and residency, he was not instructed to check with the pharmacy to see if a patient was seeking or receiving early refills. He was not aware pharmacies were filling prescriptions early. He never heard that the standard of care required him to make inquiries to the pharmacy, and he was surprised when he learned the pharmacy had dispensed early refills, as he would have expected the pharmacy to call him after the first time. It was also not Dr.

Kingsbury's experience that pharmacists were known to dispense medication early; he had never heard of that being a problem from any colleague.

83. Regarding the Xanax and Ambien prescriptions, Dr. Kingsbury stated that his prescriptions would typically say "every night as needed," but that he would coach the patient to use the medication four to five times a week at most to avoid tolerance and to promote efficacy. Therefore, the notations in the medical records about limiting to three to five times a week concerned his verbal instructions to the patient. He also discussed the patient's history of abuse with the patient because Dr. Kingsbury wanted the patient to be careful with his medications and not overuse them.

84. Dr. Kingsbury noted that he was also well aware of the contraindication of Vicodin and benzodiazepines; that both can be sedating and that there was the danger of respiratory suppression.

85. Dr. Kingsbury felt shocked and awful after he learned of the patient's death in 2013. As a result, he thought about what he could have done better, and he wanted to make sure he did the right thing. This was the first and only time something like this had ever happened in his practice. The situation with this patient "squashed" him. Everything had to change. Even though Dr. Kingsbury had a lot of experience dealing with difficult patients and prescribing medications, it "still happened to" him, and it was "shameful."

86. Dr. Kingsbury instituted the following changes to his practice in 2013:

- He required patients treated with narcotics to enter into a "Narcotic Medication Agreement";
- He prepared a pamphlet titled, "Opioid Analgesic Medication Information" that he gave to patients on chronic opioid prescriptions, and he discussed the risks and benefits of such medications with them;
- He began requiring patients on pain medications to see him every other prescription;

- He stopped writing refills for these types of medications;
- He began requiring drug screens once to twice a year depending on the circumstances; and
- He improved his documentation regarding the type of pain, the location of the pain, its impact on activities of daily living, and improvement of function.

87. Dr. Kingsbury acknowledged that his record keeping was below the standards he wanted to meet, and he voiced concern during his hearing testimony because he could not tell what happened regarding certain aspects of his care of the patient from his own records. He described his documentation as "lacking all over the place."

88. Dr. Kingsbury noted changes in the law and medical community that have helped him more safely care for his patients, including:

- Vicodin became a Schedule II controlled substance in 2014 so refills were no longer allowed;
- The CURES system has gotten less laborious to use; and
- Since 2016, the law changed, mandating that he check CURES before each new prescription and then quarterly, which he has been doing as required.

89. After the accusation was filed, Dr. Kingsbury attended UCSD's School of Medicine Continuing Medical Education Medical Record Keeping Course on May 2 to 3, 2019, and Physician Prescribing Course on January 14 to 16, 2019.

90. Dr. Kingsbury noted that patients can still be disingenuous with him. "But there are more checks in place along the way" so he "can pick up on it earlier." If Dr. Kingsbury encountered a similar patient now, he believed he would handle the situation differently, including:

- If the patient wanted narcotics, he would not prescribe them at all, or it would be harder to get him to prescribe them;
- If the situation looked complex and he felt the "vibe" of being used, he would at least get another doctor to review the case with him;
- He would document better;
- He would be more controlled in his prescribing;
- He would still need to be on guard, but there are now other things, such as changes in the law, that would help him maintain better control;
- Dr. Kingsbury also started using a new system called "Electronic Prescribing Controlled Substances (EPCS)" that allows him to see every prescription and refill in real time. This system, which he described as very "lock step," makes it more difficult to overprescribe because he can see when prescriptions are dispensed through CURES.

Character Evidence

91. Dr. Kingsbury called to two character witnesses, Laurance Davis Cracroft, M.D., and Howard Williams, M.D., both of whom have known Dr. Kingsbury since he started his internship in 1996 at Scripps Mercy Hospital. Both Dr. Cracroft and Dr. Williams wrote glowing reference letters, which were received in evidence as administrative hearsay and supplemented and explained their hearing testimony. (Gov. Code, § 11513, subd. (d).)

92. Dr. Cracroft practiced emergency medicine at Scripps Mercy Hospital from 1978 until he retired in December 2018. Dr. Cracroft did not socialize with Dr. Kingsbury, but he said they had become friends "as much as that is allowed." Dr. Cracroft helped train Dr. Kingsbury when he was an intern at Scripps Mercy approximately 23 years ago. Over the years, Dr. Kingsbury has called the emergency department to admit patients while Dr. Cracroft was working there. Dr. Cracroft also

noted that Dr. Kingsbury had been part of the training faculty and worked in the Behavioral Health Unit at Scripps Mercy Hospital. Dr. Cracroft said Dr. Kingsbury did a "great job" as a teacher at the hospital.

Dr. Cracroft also served for over 20 years on the Quality and Credentialing Board at Scripps. Any doctors with any limitations in ability were brought before that Board, and Dr. Kingsbury has never been among the doctors that were scrutinized.

Dr. Cracroft was aware of the accusation, but he only knew a "general outline" of the charges. He did not know the details of the patient care provided, other than that it concerned narcotics and that the patient overdosed to end his life. Dr. Kingsbury asked him to write a letter on his behalf, and before completing it, Dr. Cracroft checked the opinions of some others who had worked with Dr. Kingsbury. Because they all praised Dr. Kingsbury, Dr. Cracroft felt confident writing his letter after speaking with them.

In his June 12, 2019, letter, Dr. Cracroft wrote the following:

> I have had the pleasure of working closely with Grant Kingsbury, MD, at Scripps Mercy Hospital for over 23 years. In my varied roles as an emergency physician, chair of the emergency department, previous chief of staff, and longstanding Scripps Mercy Senior Medical Director, I have frequently interacted on many levels with Grant during his career at Scripps Mercy Hospital. . . . Throughout this time his personal and professional interactions with staff and patients have been exemplary. Grant is a dedicated care giver, a superb clinician, and an accomplished teacher. Since completing his residency Grant has continuously served as a distinguished member of our teaching faculty. . . .

> . . . Though the stress can on occasion be palpable in our inner city, high acuity hospital, Grant always remains cool and controlled even under the most intense situations. Grant always demonstrates the highest ethical standards; he is honest, straightforward, and fair in his dealings with others.

93. Dr. Williams operates a private internal medical practice in the same medical office building where Dr. Kingsbury works. They are both members of Mercy Physicians Medical Group (MPMG), which is an independent practice association (or IPA). They see each other regularly at IPA meetings and in the building, although they do not socialize.

According to Dr. Williams, Scripps Mercy Hospital is a well-known quality learning institution that attracts good interns and residents, and Dr. Kingsbury was in the top quarter of his class when he trained there. Scripps Mercy oversees all its physicians and requires that they all to be recertified every two years. Dr. Williams was not aware of any problems with Dr. Kingsbury at the hospital.

Dr. Williams described Dr. Kingsbury as conscientious, hardworking, a quick learner, and a good physician. Dr. Williams has regularly referred patients to Dr. Kingsbury. Dr. Williams considered Dr. Kingsbury to have an "excellent" character for honesty and truthfulness. Dr. Williams also noted that Dr. Kingsbury was among the "Top Docs" listed in San Diego Magazine's May 2012 issue.

Dr. Williams saw the accusation and discussed it with Dr. Kingsbury. Dr. Williams noted that it was "not a good reflection of" Dr. Kingsbury's "style," and he had never seen a similar example.

In his March 24, 2019, letter, which he re-signed at the hearing, Dr. Williams described Dr. Kingsbury during his three-year internship and residency as "clearly well-educated, hard-working and thoughtful. He was at least in the top quarter of a class that was extremely talented." He also wrote that "[a]fter all I know about his

training, his work ethic, his character and the allegations that have been brought forth, I would gladly send a relative to him for medical care."

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of a disciplinary action is not to punish, but to protect the public, and the inquiry must be limited to the effect of the physician's actions upon the quality of his service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) It is far more desirable to impose discipline before a licensee harms any patient than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.)

The Burden and Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (*Martin v. State Personnel Board* (1972) 26 Cal.App.3d 573, 582.)

3. The standard of proof in an administrative action seeking to suspend or revoke a physician's and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

4. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high probability. The evidence must be so clear as to leave no substantial

doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

5. In a disciplinary proceeding, the burden is on Respondent to produce positive evidence of rehabilitation. (*Epstein v. California Horse Racing Board* (1963) 222 Cal.App.2d 831, 842-843.)

Statutory Disciplinary Authority

6. Business and Professions Code section 2227 provides:

> (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.

7. Business and Professions Code section 2229 provides:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement

program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

8. Business and Professions Code section 2234, subdivisions (a), (b), (c), and (d), provide:

> 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.

(d) Incompetence.

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

Statutory Authority Regarding Prescribing Practices

10. Business and Professions Code section 725 provides:

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

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

for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

11. Business and Professions Code section 2241 states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

12. Business and Professions Code section 2241.5 provides:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.[30]

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[30] Section 2241.5 was amended effective January 1, 2016. The amendment changed only subdivision (c)(3), which included the following language in effect between January 1, 2007 and December 31, 2015: "Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs." The recent amendments

[¶] . . . [¶]

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

13. Business and Professions Code section 2242, subdivision (a),[31] provides:

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

Statutes of Limitations

14. Business and Professions Code section 2230.5, subdivision (a), provides:

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to this subdivision concerned recommending medical cannabis, which is not at issue in this matter.

[31] The remaining subdivisions of this section include exceptions which do not apply to this case, such as prescriptions given during the absence of the patient's regular physician.

> (a) Except as provided in subdivisions (b), (c), and (e),[32] any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

Pertinent Case Law

STANDARD OF CARE

15. The law is well established that "[t]he standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts." (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753.) In *Sinz*, the California Supreme Court explained (*Ibid.*):

> The criterion in this regard is not the highest skill medical science knows; "the law exacts of physicians and surgeons in the practice of their profession only that they possess and exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances." [Citation.] The proof of that standard is made by the testimony of a physician qualified to speak as an expert . . . . He must have had basic educational and professional training as a general foundation for his testimony, but it is a practical knowledge of what is usually and customarily done by

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[32] Subdivisions (b), (c), and (e) concern exceptions to the statute of limitations that are not applicable here.

> physicians under circumstances similar to those which confronted the defendant charged with malpractice that is of controlling importance in determining competency of the expert to testify to the degree of care against which the treatment given is to be measured.

16. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. [Citations.] The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. [Citations.]" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86; *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; see also, *Borrayo v. Avery* (2016) 2 Cal.App.5th 304, 310-311, regarding formulating the standard of care as that of physicians in similar circumstances rather than similar locations.) A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

17. The standard of care must be provided through expert testimony. (*Sinz, supra,* 33 Cal.2d at p. 753; See also *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215-219.) "The party offering the expert must demonstrate that the expert's knowledge of the subject is sufficient, and the determinative issue in each case is whether the witness has sufficient skill or experience in the field so his testimony would be likely to assist" the trier of fact. (*Id.* at p. 219.) The expert's qualifications must establish that he or she has "the education, training, experience, or knowledge necessary to testify to the standards to be upheld in the practice" of the profession on which he or she is opining. (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 947.)

SIMPLE AND GROSS NEGLIGENCE

18. While a lack of ordinary care defines negligent conduct, gross negligence is defined by an error or omission that is egregious and flagrant. "Gross negligence has been said to mean the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Construction Co.* (1946) 46 Cal.2d 588, 594; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

19. The concept of "gross negligence" was explained in the context of a disciplinary proceeding against a doctor in *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184. In that case, the doctor was accused if gross negligence with respect to his post-operative care of a patient, "by failing to diagnose, monitor and take sufficient steps to remedy a fluid and salt imbalance in the patient." (*Id.* at p. 189.) The administrative judge's proposed decision found that the doctor was negligent but concluded he did not engage in gross negligence. The Board declined to adopt the proposed decision and instead decided that Dr. Gore had committed gross negligence. (*Id.* at pp. 189-190.) The appellate court noted that although an administrative law judge's decision may be entitled to great weight regarding his assessment of the credibility of witnesses, the Board properly rejected the proposed decision because it "was based upon a mistaken belief of the administrative law judge that, under the circumstances of this case, 'gross' negligence would have required petitioner's conduct to be a cause of the patient's death." (*Id.* at p. 190.) After noting that Business and Professions Code section 2234 does not define "gross negligence," the appellate court reviewed the definitions provided in other appellate decisions as follows (*Gore, supra*, 110 Cal.App.3d pp. 196-198):

> In *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 123 Cal.Rptr. 563, the court was called upon to determine the meaning of the words "grossly negligent" in section 2960 as applicable to the conduct of a psychologist whose license had been revoked. After holding that substantial evidence supported the trial court's

findings, the court said (49 Cal.App.3d p. 941, 123 Cal.Rptr. p. 569): "Section 2960, subdivision (i), provides that a psychologist's license may be revoked if he is 'grossly negligent in the practice of his profession.' The California Supreme Court in *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594, 297 P.2d 644, defined 'gross negligence' as 'the want of even scant care or an extreme departure from the ordinary standard of conduct.' Dr. Mervin Freedman, whose qualifications were not challenged by appellant, testified that conduct such as that described in findings 3 and 5 constituted an 'extreme departure from the standard of practice of psychology.'"

As shown above, two of the medical expert witnesses in the instant case, Drs. Gerber and Silverman, testified that Dr. Gore's treatment of his patient was "an extreme departure" from standard medical practice. They were not asked and did not testify as to whether or not that treatment denied the patient "even scant care." Petitioner contends that failure to cover that aspect of the *Van Meter* definition leaves the evidence insufficient to support the findings of gross negligence. We disagree.

The language used by the *Van Meter* court is in the disjunctive, indicating that gross negligence could consist of either want of even scant care or extreme departure from the ordinary standard of conduct, but not necessarily both. In *Cooper, supra*, the court's statement that gross negligence had been defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct" is immediately followed by the statement that a medical witness testified that the accused's conduct

"constituted an extreme departure from the standard of practice of psychology," without mentioning whether or not it amounted to want of scant care. The implication is that proof of either, but not necessarily both elements, is sufficient.

This conclusion is confirmed by the authorities cited in *Van Meter, supra*, at page 595, 297 P.2d 644, in support of that court's definition of gross negligence. In *Kastel v. Stieber* (1932) 215 Cal. 37, 47-51, 8 P.2d 474, the court rejected the notion that gross negligence, as that term was used in our automobile guest statute, in effect in October 1929 (Cal.Veh. Act, § 1413/4), meant some degree of wantonness or willfulness. Indicating its adherence to definition of gross negligence as "a want of slight diligence" (215 Cal. pp. 46-47, 8 P.2d 474, 480) the court concluded that, "It must always be borne in mind that a state of facts relating to an automobile accident out on the open highway cannot be controlling as to the conclusions to be reached upon a corresponding state of facts occurring within city limits. The former might only reasonably be held negligence, while in the latter, owing to the difference in the hazardousness of the situation, gross negligence would only be the right conclusion."

Prosser on Torts (1941), p. 260, also cited by the *Van Meter* court for its definition of gross negligence, reads as follows:

"Gross Negligence. This is very great negligence, or the want of even scant care. It has been described as a failure to exercise even that care which a careless person would use. Many courts, dissatisfied with a term so devoid of all

real content, have interpreted it as requiring wilful misconduct, or recklessness, or such utter lack of all care as will be evidence of either-sometimes on the ground that this must have been the purpose of the legislature. But most courts have considered that 'gross negligence' falls short of a reckless disregard of consequences, and differs from ordinary negligence only in degree, and not in kind. So far as it has any accepted meaning, it is merely an extreme departure from the ordinary standard of care." (Emphasis added.)

Read in light of the authorities thus cited by the *Van Meter* court, the definition of gross negligence in *Van Meter* and *Cooper* means a want of even slight care, but not necessarily involving wanton or wilful misconduct; in other words, an extreme departure from the ordinary standard of care.

Negligence and gross negligence are relative terms. "The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater, the actor is required to exercise caution commensurate with it." (Prosser, Law of Torts (4th ed. 1971), at p. 180.)

In the instant case, Mrs. D'Abusco, having a history of impaired health and following major surgery, was wholly dependent on Dr. Gore for adequate post-operative care. Substantial evidence shows that he failed to exercise the standard of care in diagnosis, monitoring and treatment that is basically and routinely taught to students in medical school. Thus, management of his patient was an extreme

> departure from the standard of medical care, which we hold to be the equivalent of "want of even scant care" under the circumstances of this case.

REPEATED NEGLIGENT ACTS

20. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

INCOMPETENCE

21. "Incompetence" was defined in *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054, in which Dr. Kearl was disciplined for the manner in which he administered anesthesiology on two patients. In that case, the Medical Board found that he engaged in gross negligence with respect to one patient and was incompetent in his choice of the anesthetic to use on the other patient. The appellate court explained the meaning of "incompetence" as follows (*Id.* at pp. 1054-1055):

> The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837, 149 Cal.Rptr. 787.) Incompetency is distinguishable from negligence, in that one "may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*, at p. 838, 149 Cal.Rptr. 787.) Thus, "'a single act of negligence . . . may be attributable to remissness in discharging known duties, rather than . . . incompetence respecting the proper performance.'" (*Ibid.*, quoting from *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62, 116 P. 400.) The *Pollack*

> court concludes: "While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a general lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute, we reject the notion that a single, honest failing in performing those duties-without more-constitutes the functional equivalent of incompetency justifying statutory sanctions." (85 Cal.App.3d at p. 839, 149 Cal.Rptr. 787, emphasis original.)

In the *Kearl* case, the appellate court concluded that the evidence supported the Medical Board's decision that Dr. Kearl was incompetent in his treatment of one patient based on expert testimony that he engaged in flawed reasoning when he chose an anesthetic which lead to a negligent act. (*Kearl, supra*, 189 Cal.App.3d at pp. 1055-1056.)

EVALUATION OF EXPERT OPINION TESTIMONY

22. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) "Like a house built on sand, the expert's opinion is no better than the facts on which it is based. . . . [W]here the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony." (*Ibid.*)

23. An expert witness "does not possess a carte blanche to express any opinion within the area of expertise. [Citation.]" *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.) "Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.]" (*Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36.)

24. Relying on some but not all of an expert's opinions may be entirely appropriate. "It is well settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also '"reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material.'" (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 777.) Furthermore, the fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

Evaluation of the Existence of Cause to Discipline Dr. Kingsbury

25. There was no dispute that while he was treating the patient, Dr. Kingsbury was well aware that the patient suffered from liver disease and had a history of substance abuse. Dr. Kingsbury prescribed Vicodin, which contains both hydrocodone, an addictive opioid pain medication, and acetaminophen, which Dr. Kingsbury was well aware should be limited for all patients and even more limited for patients with liver disease. The medical records indicated Dr. Kingsbury prescribed Vicodin for cough and for unidentified pain, which Dr. Kingsbury later indicated in the medical records was located in the patient's low back.

26. On November 21, 2011, Dr. Kingsbury learned from the patient that he believed he was addicted to Vicodin, and the pharmacist reported to Dr. Kingsbury that for several months the patient had been obtaining monthly supplies of Vicodin in two to three-week intervals and was at "toxic" levels. In the face of these red flags, Dr. Kingsbury continued to prescribe Vicodin to the patient even though the patient failed to heed Dr. Kingsbury's instructions to taper off the medication and the patient was taking more acetaminophen than was safe for a patient with liver disease.

27. Dr. Kingsbury also prescribed Ambien and Xanax, although not both during the same timeframes. Ambien was prescribed for months before it was ever

noted in the medical records, and even then, the medical indication noted, for insomnia, was contradicted by other notes in the records that stated the patient was sleeping well. When Dr. Kingsbury stopped prescribing Ambien, and started prescribing Xanax, the indications varied from anxiety, to insomnia, to muscle spasm. Again, the indication for insomnia was contradicted by other notes in the medical records that the patient was sleeping well. Dr. Kingsbury was aware that both Ambien and Xanax can be habit forming and that benzodiazepines, like Xanax, in combination with opioids, such as the hydrocodone in Vicodin, can lead to respiratory suppression if the medications are misused. But the medical records did not indicate that Dr. Kingsbury ever discussed the dangers of taking Vicodin together with Xanax, a benzodiazepine, or Ambien, a benzodiazepine analog, even though Dr. Kingsbury was aware before he began prescribing Ambien or Xanax that the patient had been taking more Vicodin than Dr. Kingsbury intended.

28. After the patient reported to Dr. Kingsbury in June 2012 that he had been able to stop using Vicodin, which had resulted in severe withdrawal symptoms, Dr. Kingsbury again prescribed Vicodin to the patient in September 2012 based on a telephone message from the patient that he was suffering from back pain. Dr. Kingsbury did not examine the patient or note any type of assessment of the patient's claimed pain before reinitiating the Vicodin prescriptions. Then Dr. Kingsbury authorized multiple refills of Vicodin, even though Dr. Kingsbury was concerned the patient was using more than Dr. Kingsbury intended.

29. Dr. Kingsbury repeatedly authorized early refills of prescriptions when the patient claimed he needed them because he was going on vacation, lost his medication, vomited on his medications, and that he needed the Vicodin for low back pain resulting from a club foot and later from a Go Kart accident.

30. Although Dr. Kingsbury was aware the patient was using the medication for non-medically indicated reasons and he counseled the patient to taper his use of Vicodin, Dr. Kingsbury continued to prescribe an excessive amount of the medication, including prescribing 240 Vicodin tablets at the last appointment, when the patient had

told him he had suicidal ideations and a follow up appointment was set in two weeks. Even Dr. Kingsbury testified that prescribing that amount of Vicodin at that appointment was "ridiculous."

31. Dr. Kingsbury did not dispute that his medical records were not accurate or complete, and even he could not figure out why he did what he did from a review his own records.

32. As was explained by Dr. Franklin, Dr. Kingsbury engaged in multiple gross departures from the standard of the standard of care and some simple departures from the standard of care; prescribed excessive amounts of the medications Vicodin, Ambien, and Xanax to a patient he knew suffered from substance abuse disorder, opioid dependence, and liver disease; failed to maintain accurate and complete medical records of his treatment of this patient; demonstrated, particularly with respect to his repeated prescriptions of Vicodin to this patient and failure to control the patient's access to the medication after he was well aware the patient was misusing medication, a lack of knowledge (in other words incompetence) in his care and treatment of this patient; and prescribed dangerous drugs without a proper examination and appropriate medical indication.

33. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), because Dr. Kingsbury committed gross negligence in his treatment and care of the patient.

34. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), because Dr. Kingsbury committed repeated negligent acts in his treatment and care of the patient.

35. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227,

2234, and 725 because Dr. Kingsbury committed repeated acts of clearly excessive prescribing of drugs to the patient.

36. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227, 2234, 2266 because Dr. Kingsbury failed to maintain adequate and accurate records of his treatment and care of the patient.

37. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), because Dr. Kingsbury demonstrated a lack of knowledge (incompetence) in his treatment and care of the patient.

38. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2242, subdivision (a), because Dr. Kingsbury prescribed dangerous drugs without an appropriate prior examination and medical indication.

Considerations Regarding Appropriate Level of Discipline

39. California Code of Regulations, title 16, section 1361, subdivision (a), provides:

> (a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts

> of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

40. The Disciplinary Guidelines "set forth the discipline the Board finds appropriate and necessary for the identified violations." Disciplinary recommendations set forth in the Disciplinary Guidelines are meant to "promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection." The Disciplinary Guidelines also state:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board - ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

41. The Disciplinary Guidelines recommend revocation as the maximum discipline for all the categories of misconduct found in this matter. The Disciplinary Guidelines recommend the following minimum levels of discipline:

- For gross negligence, repeated negligent acts, and/or incompetence under Business and Professions Code section 2234, subdivisions (b), (c), and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices.

- For excessive prescribing under Business and Professions Code section 725 or Prescribing without an appropriate prior examination under Business and Professions Code section 2242, revocation, stayed, and five years' probation, with conditions including a 60-day suspension, a Drug Enforcement Administration (DEA) controlled substances restriction, maintenance of controlled substance records, education course, prescribing practices course, medical record keeping course, professionalism course, clinical competence course, and monitoring.

Evaluation

42. Dr. Kingsbury has practiced medicine for over 20 years without any prior discipline. The conduct at issue was very serious and involved numerous failures to meet the standard of care related to a single patient and medical records that did not provide accurate or complete information about the patient's care and treatment and which records were at times contradictory.

43. Dr. Kingsbury has taken what happened with this patient very seriously, and he credibly acknowledged his responsibility and expressed his remorse and regret. Shortly after learning that the patient had taken his own life by overdosing on controlled substances, Dr. Kingsbury took proactive steps to assure that such a tragic incident does not happen again. Dr. Kingsbury prepared and began using a contract and informational pamphlet with patients to whom he prescribes opioid pain medications, he began seeing patients in person every other prescription, he began requiring drug testing once or twice a year depending on the circumstances, and he also more recently began regularly checking the CURES database on a regular basis and started using an electronic program to more closely monitor the medications dispensed to his patients in "real time."

44. After the accusation was filed, Dr. Kingsbury completed medical record keeping and prescribing courses.

45. Dr. Kingsbury called two doctors who have known him professionally for many years as character witnesses and presented letters they wrote on his behalf. Those two doctors gave glowing reports of Dr. Kingsbury's skill as a physician.

46. Complainant requested that Dr. Kingsbury's certificate be placed on probations for a term and on conditions consistent with the Disciplinary Guidelines. Dr. Kingsbury requested that the discipline imposed be a letter of reprimand and asked that he not be placed on probation. Dr. Kingsbury argued that a departure from the recommendations in the Disciplinary Guidelines was warranted because the conduct that led to this proceeding occurred over six years ago; the medical community standards and attitudes regarding the treatment of pain with opioid medication have since changed dramatically; Dr. Kingsbury regretted and took responsibility for his mistakes; and he has made changes in his prescribing and record keeping practices.

47. Despite Dr. Kingsbury's efforts to educate and rehabilitate himself and the passage of time since the incidents that resulted in this proceeding, due to his extensive, serious, and repeated departures from the standard of care during the course of his treatment of this patient, this is not a case where a letter of reprimand, which would be a significant departure from the Board's Disciplinary Guidelines, is appropriate. Dr. Kingsbury failed to maintain appropriate boundaries with a patient, allowed a person he knew suffered from substance abuse issues to manipulate him repeatedly, he overprescribed acetaminophen to a patient with liver disease, and even when he recognized that the patient needed to be weaned off the medication, he failed to take proactive steps to make sure that happened. Dr. Kingsbury also completely failed to adequately or accurately document his care of the patient.

48. Under the circumstances, it is important that Dr. Kingsbury be monitored and participate in additional education and training, including a professional boundaries program. Such educational programs are ordered in large part due to concerns that Dr. Kingsbury, who is a solo practitioner and noted that he "had a soft spot for lost souls," needs to gain the skills necessary to avoid anything similar happening in the future.

At the same time, some departures from the recommended length of probation and some of the recommended conditions are warranted here after taking the following into consideration: the amount of time that has lapsed since the treatment of the patient in question; this case involved a single patient; Dr. Kingsbury had no prior disciplinary action against his certificate; Dr. Kingsbury credibly testified about his current understanding of his errors; and Dr. Kingsbury has made important changes to how he treats patients with pain medication. Therefore, the length of probation shall be 35 months instead of five years, he shall be allowed to continue to operate as a solo practitioner while on probation, an actual suspension shall not be ordered, and no restrictions on his DEA registration or his practice shall also be required.

ORDER

Certificate No. A 64822 issued to Respondent A. Grant Kingsbury, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for 35 months 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 (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.

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 (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 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. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate Respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, Respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not Respondent successfully completed the program.

A professional boundaries 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.

If Respondent fails to complete the program within the designated time period, Respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that Respondent failed to complete the program.

6. 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.

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. 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.

7. 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.

8. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. General Probation Requirements

COMPLIANCE WITH PROBATION UNIT

Respondent shall comply with the Board's probation unit.

ADDRESS CHANGES

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

PLACE OF PRACTICE

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

LICENSE RENEWAL

Respondent shall maintain a current 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.

12. 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.

13. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

14. 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.

15. 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.

16. 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

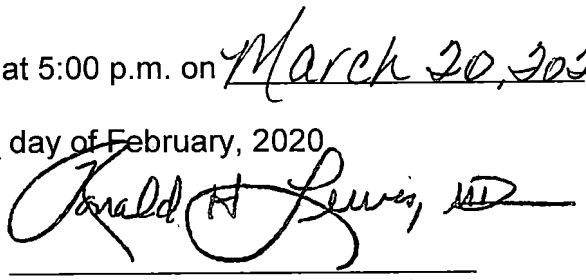
Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar 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.

17. 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.

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

IT IS SO ORDERED this 21st day of February, 2020.



Ronald H. Lewis, M.D., Chair
Panel A
Medical Board of California

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

In the Matter of the Accusation Against	)	
	)	
A. Grant Kingsbury, M.D.	)	Case No.: 800-2017-038069
	)	
Physician's and Surgeon's Certificate No. A 64822	)	OAH No.: 2019020525
	)	
	)	
Respondent	)	
	)	

ORDER OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, 920 W 17th Street, Santa Ana, CA 92706. The telephone number is (800) 231-2682

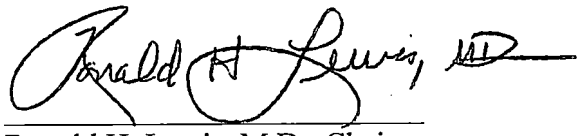
To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties' attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-2442
Attention: Andrea Geremia

Date: November 22, 2019



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:

A. GRANT KINGBURY, M.D.

Physician's and Surgeon's Certificate No. A 64822

Respondent

Case No. 800-2017-038069

OAH No. 2019020525

PROPOSED DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on July 22, 23, and 24, 2019, in San Diego, California.

Keith C. Shaw, Deputy Attorney General, Department of Justice, State of California, represented complainant Kimberley Kirchmeyer, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California.

Robert W. Frank, Attorney at Law, Neil, Dymott, Frank, McCabe & Hudson, represented respondent A. Grant Kingsbury, M.D.

The matter was submitted on July 24, 2019.

SUMMARY

This disciplinary proceeding arose after a review of corner reports uncovered that one of Dr. Kingsbury's patients committed suicide in May 2013 by overdosing on several medications, including hydrocodone and alprazolam prescribed by Dr. Kingsbury. Complainant sought to discipline Dr. Kingsbury's physician's and surgeon's certificate based on allegations that during his care and treatment of the patient Dr. Kingsbury committed gross negligence, repeated negligent acts, and repeated acts of clearly excessive prescribing of drugs; failed to maintain adequate and accurate medical records; demonstrated a lack of knowledge; and prescribed dangerous drugs without an appropriate prior examination and a medical indication. The allegations concerned Dr. Kingsbury's prescription of Vicodin (a combination of hydrocodone and acetaminophen), zolpidem (Ambien), and alprazolam (Xanax) to the patient. Complainant requested that Dr. Kingsbury be placed on probation with appropriate terms and conditions as recommended by the *Medical Board of California Manual of Model Disciplinary Orders and Disciplinary Guidelines* (12th Edition, 2016) (Disciplinary Guidelines).

Dr. Kingsbury did not dispute that he made serious mistakes during his treatment and care of the patient and that his medical record keeping was not up to the requisite standards. Dr. Kingsbury acknowledged that when the patient was under his care, he was aware of the patient's prior history of intravenous drug abuse and that the patient suffered from liver disease and opioid dependence and/or addiction. Dr. Kingsbury admitted he allowed the patient to manipulate him and he mistakenly believed, at the time the patient was under his care, that he was the best physician for

the patient. Dr. Kingsbury expressed his shame, humiliation, and regret for the manner in which he cared for the patient. He asserted that he had since sufficiently changed his prescribing and record keeping practices to assure that nothing similar ever happens again. Dr. Kingsbury argued that a public reprimand was warranted under the circumstances.

Complainant proved by clear and convincing evidence that Dr. Kingsbury engaged in gross negligence, repeated negligent acts, and repeated acts of excessive prescribing; failed to maintain accurate and adequate medical records; demonstrated a lack of knowledge; and prescribed dangerous drugs without an appropriate prior examination and a medical indication. Based on the evidence presented, a 35-month term of probation, with conditions requiring supervision and additional training, including participation in a clinical assessment program, is the necessary and appropriate level of discipline to assure public protection under the circumstances.

FACTUAL FINDINGS

Licensing and Jurisdictional Background

1. On April 10, 1998, the board issued Physician's and Surgeon's Certificate No. A 64822 to Dr. Kingsbury. His certificate was in full force and effect at all times relevant to this proceeding and will expire on December 31, 2019, unless renewed. There have been no prior disciplinary actions against Dr. Kingsbury's certificate.

2. Complainant signed the accusation in her official capacity on January 3, 2019. The accusation alleged Dr. Kingsbury subjected his certificate to discipline pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), by committing gross negligence in his care and treatment of the patient (First Cause for

Discipline); pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), by committing repeated negligent acts in his care and treatment of the patient (Second Cause for Discipline); pursuant to Business and Professions Code sections 725, 2227, and 2234, by committing repeated acts of clearly excessive prescribing of drugs to the patient as determined by the standard of the community of physicians (Third Cause for Discipline); pursuant to Business and Professions Code sections 2227, 2234, and 2266, by failing to maintain adequate and accurate medical records regarding his care and treatment of the patient (Fourth Cause for Discipline); pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), by demonstrating a lack of knowledge in his care and treatment of the patient (Fifth Cause for Discipline); and pursuant to Business and Professions Code section 2242, subdivision (a), by prescribing dangerous drugs without an appropriate prior examination and a medical indication (Sixth Cause for Discipline).

3. Dr. Kingsbury timely submitted a notice of defense, and this hearing followed.

Dr. Kingsbury's Education, Background, and Medical Practice

4. Dr. Kingsbury is an internist and primary care physician. He is not an addiction or pain management specialist. He obtained his Bachelor of Science Degree in Psychobiology from Pitzer College in 1984; his Master of Science Degree in Physiology from the University of California, Davis in 1988; and his Medical Degree from Loyola Stritch University School of Medicine, in Chicago, in 1996. He completed an internship in internal medicine in 1997 and an internal medicine residency in 1999, both at the Scripps Mercy Hospital Internal Medicine Program. After finishing his residency, Dr. Kingsbury worked for Scripps Mercy Medical Group in Poway, California

from August 1999 to December 1999 and for Graybill Medical Group in Poway, California from December 1999 to May 1, 2000.

5. On May 1, 2000, Dr. Kingsbury acquired an internal medicine private practice in San Diego, California, which he has continued to operate and has always operated as a solo practitioner. He has typically had five or six employees, including medical assistants, billers, and front desk personnel. His office is across the street from Scripps Mercy Hospital, and in addition to his office-based practice, Dr. Kingsbury sees patients at Scripps Mercy Hospital. Dr. Kingsbury estimated that he typically sees patients for one-third to one-half of the time he is in the office, and he spends the rest of the time, when he is not at the hospital, doing charting. Dr. Kingsbury pointed out during his testimony that he strives to maximize the amount of time he spends with each patient. In order to allow him to spend more time with each patient, he does not take notes between patients. Instead, he does his charting later. Approximately two percent of his patient population have been treated for pain, which amounted to 20 to 30 patients.

6. For the past 18 years, Dr. Kingsbury has also provided internal medicine consultations in the Behavioral Health Unit at Scripps Mercy Hospital. He does this work six days a month and he is "on call" 24 hours during those days. Dr. Kingsbury described his work in the Behavioral Health Unit as "more difficult" and said it "stretches him," meaning that it takes him out of his "comfort zone." A lot of patients in that unit suffer from substance abuse disorders and dual diagnoses, including patients diagnosed with bi-polar disorder and personality disorders. With the patients in that unit, communication may be more difficult, the patients may not always tell the truth, and they may be manipulative. Dr. Kingsbury noted that there can be some anxiety associated with caring for those types of patients.

7. Additionally, Dr. Kingsbury has taught new residents and interns at Scripps Mercy Hospital for the past 18 years. University of California San Diego (UCSD) Medical School students also participate in that training. Dr. Kingsbury estimated that he has spent about 20 to 25 percent of his professional time teaching. In 2018, Dr. Kingsbury received an award from UCSD for being a "teacher of excellence" at Scripps Mercy Hospital.

8. Dr. Kingsbury received San Diego Magazine's "Top Doctor" award in the field of Internal Medicine in 2012. He was elected by his peers and was quite proud of receiving that award, which was publicized in the May 2012 issue of the magazine.

Treatment of Pain and the Opioid Crisis

9. The treatment and care of the patient at issue in this matter occurred during a time when the extent of what is now commonly referred to as the "Opioid Crisis" was not fully understood in the medical community. When Dr. Kingsbury was trained as a doctor, he learned that pain should be treated as the "fifth vital sign." However, treatment of pain with opioid medication has changed since Dr. Kingsbury became a physician, and he explained during his hearing testimony that he has come to understand the number of opioid prescriptions peaked during 2011 and 2012. Dr. Kingsbury submitted a May 5, 2017, article titled "The Joint Commission's Pain Standard: Origins and Evolution," which described the history of the assessment and treatment of pain. That article was received as administrative hearsay and was considered to the extent it supplemented and explained Dr. Kingsbury's and complainant's expert Robert M. Franklin, M.D.'s testimony. (Gov. Code, § 11513, subd. (d).)

10. During the timeframe when the patient was treated by Dr. Kingsbury, the board's "Guidelines for Prescribing Controlled Substances for Pain" (adopted in 1994 and amended in 2007) (Pain Treatment Guidelines) were in effect.[1] The Pain Treatment Guidelines explained that the standard of care had "evolved over the past several years" such that a physician was "permitted to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances." The Pain Treatment Guidelines stated: "The board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly, and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists"; "[m]edications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, or cancer"; and "opioid analgesics for patients with pain may also be beneficial, especially when efforts to alleviate the pain with other modalities have been unsuccessful." However, the Pain Treatment Guidelines also cautioned:

> Inappropriate prescribing of controlled substances, including opioids, can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs.

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[1] Dr. Franklin considered these guidelines when forming his opinions, which are described later in this decision.

The Medications at Issue in this Matter

11. This case focused on Dr. Kingsbury's prescriptions of Vicodin, alprazolam (Xanax), and zolpidem (Ambien)[2] to the patient. Dr. Franklin's expert report, which was received in evidence without objection, supplied information about these three medications, both Dr. Franklin and Dr. Kingsbury testified about these medications, and the scheduling of these drugs is set forth in the code sections cited below.

12. Vicodin is a combination of hydrocodone and acetaminophen and was, at the time, 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. In 2014, Vicodin was rescheduled as a Schedule II drug (Health & Saf. Code, § 11055, subd. (b)(1)(I)).The Vicodin tablets Dr. Kingsbury prescribed to the patient were 5/500 strength, meaning each tablet contained 5 mg of hydrocodone and 500 mg (or 0.5 g) of acetaminophen. Hydrocodone is an opioid pain medication and acetaminophen is the generic name for the analgesic/antipyretic medication commonly referred to by the brand name Tylenol. The maximum daily dose anyone should take of acetaminophen is 4,000 mg per day (or 4 g per day). For

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[2] Although the accusation listed Citalopram, a selective serotonin reuptake inhibitor (SSRI) and Clonazepam (known by the trade name Klonopin) as among the "pertinent drugs," there were no allegations in the accusation, nor was evidence presented at hearing, that either of those two drugs was prescribed by Dr. Kingsbury. Additionally, even though complainant's expert provided opinion testimony about another medication, the antidepressant Lexapro (escitalopram), there were no allegations in the accusation that Dr. Kingsbury subjected his certificate to discipline by prescribing that drug to the patient.

long term use, a lower maximum dose of 2,000 to 3,000 mg is commonly recommended. Additionally, limiting the dose to no more than 2,000 mg per day is safer for patients with liver disease. Therefore, the maximum number of Vicodin 5/500 tablets someone without a compromised liver should take was 8 tablets per day (so as not to exceed 4,000 mg (or 4g) of acetaminophen per day), and the best practice for someone with liver disease would be to limit consumption to 4 tablets per day (no more than 2,000 (or 2g) of acetaminophen per day). Acetaminophen toxicity can generally occur in two patterns: acute toxicity due to overdose or chronic toxicity from excessive use over time.

13. Alprazolam (also referred to by the brand name Xanax) is a short acting benzodiazepine and a centrally acting hypnotic-sedative. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is used for management of anxiety disorders. When combined with opioids, benzodiazepines, such as alprazolam, can cause respiratory suppression and profound central nervous system suppression. The prescriptions Dr. Kingsbury wrote the patient for alprazolam were all 0.5 mg strength tablets.

14. Zolpidem (also referred to under the brand name Ambien) is a non-benzodiazepine hypnotic of the imidazopyridine class and is a central nervous system suppressant. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug pursuant to Business and Professions Code section 4022. Zolpidem is used for the short-term treatment of insomnia. The zolpidem prescriptions Dr. Kingsbury wrote the patient were all 10 mg strength tablets.

Dr. Kingsbury's Treatment and Care of the Patient

15. The evidence of Dr. Kingsbury's treatment and care of the patient consisted of the patient's medical records, a CURES[3] report of prescriptions dispensed by pharmacies to the patient, two letters from Dr. Kingsbury, the transcript of Dr. Kingsbury's subject interview, and his hearing testimony. The patient's medical records did not clearly or consistently state what medications were prescribed or when, and there were no prescription records offered as evidence. Dr. Kingsbury explained during his hearing testimony that he no longer had the prescription records because, at the time, he only maintained paper prescription records, which were kept separate from the medical records, and the prescription records were shredded after one year if there were no problems with the prescriptions.[4] Beginning in 2009, the medical records consisted primarily of electronic progress notes and electronic telephone encounter notes. Dr. Kingsbury used an electronic "eClinicalWorks" medical record system. Using that system, he could "lock" the electronic records. While the telephone encounter

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[3] The Controlled Substance Utilization Review and Evaluations System (CURES) is a database of all Schedule II, III, and IV controlled substance prescriptions dispensed in California. (See Health & Saf. Code, § 11165 et seq.) A CURES report regarding all the prescriptions dispensed to the patient during the relevant time period, printed on January 7, 2016, was received in evidence. Dr. Kingsbury's medical records did not include any CURES or similar reports printed during the course of his treatment of the patient.

[4] However, the fact that the patient overdosed on medications Dr. Kingsbury prescribed would appear to be a "problem" with the prescriptions, which arguably might have warranted retention of those records.

records received as evidence were "locked," Dr. Kingsbury was not in the habit of "locking" the progress notes. When he printed the progress notes to be given to the investigator in 2018, the progress notes were then locked and signed on the date they were printed. While records could have been modified before they were locked, Dr. Kingsbury denied making any changes to the electronic medical records after he treated the patient and/or before he submitted the records to the investigator.[5]

16. The accusation included allegations dating back to 2003. However, the accusation also clearly stated in a footnote that any conduct occurring more than seven years before it was filed was only alleged for informational purposes and was not alleged as the basis for any discipline.[6] While Dr. Kingsbury's treatment and care of the patient before 2012 may not be the basis for discipline, the history of such prior treatment was important to understand the information Dr. Kingsbury had about the patient during his care and treatment from January 2012 through May 2013.

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[5] Complainant did not allege Dr. Kingsbury falsified or otherwise altered the medical records.

[6] Business and Professions Code section 2230.5, subdivision (a), states: "Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first."

JANUARY 2003 THROUGH DECEMBER 2011

17. The patient's first visit with Dr. Kingsbury was on January 28, 2003, when the patient was 56 years old. Dr. Kingsbury remained the patient's primary care physician for over 10 years through the patient's last office visit on May 8, 2013, when the patient was 66 years old. At the first office visit in January 2003, the patient reported a history of intravenous drug use during the 1960s, hepatitis C in 1969, gastroesophageal reflux disease (GERD), club foot, and that he had quit using alcohol in 1987. Dr. Kingsbury treated the patient for a variety of conditions over the years, including GERD, back pain, and hypertension (HTN).

18. On September 22, 2009, Dr. Kingsbury began prescribing the patient Vicodin 5/500, one tablet as needed for pain every six hours. On a Progress Note, dated September 27, 2010, Dr. Kingsbury recorded that the patient was taking Vicodin "as a cough suppressant - has no pain"; the patient's "Cough - responds to vicodin";[7] and Dr. Kingsbury prescribed one tablet of 5/500 Vicodin every six hours "as needed for pain."

19. On November 21, 2011, Dr. Kingsbury learned that both the patient and the pharmacy had concerns about the patient's consumption of Vicodin. Dr. Kingsbury received the following telephone message taken at 9:30 a.m. that day: "pt states is going to stop taking the hydrocodone, and there might be some problems. he would like to have you call him today and discuss this problem." Dr. Kingsbury spoke to the

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[7] The capitalization and punctuation are quoted verbatim from the medical records in this decision.

patient later that day and wrote the following "Action Taken" at 10:13:53 a.m. on the November 21, 2011, telephone encounter record:

> [W]ill quit the vicodin, feels it's an addiction, wants to wean [*sic*] it - was up to 14/day, now down to 8/day. wants to go lower - I recommended he begin with 7/day x one week, then 6/day for one week, etc until weaned - still on naprosyn vicodin was mainly to suppress a cough for work - *ST[8] - please call in vicodin #240 2 qid prn pain w 1 refill to above rite aid - also, please call him to schedule a "Welcome to Medicare" physical exam.

At 11:54 a.m. the same day, Dr. Kingsbury's medical assistant provided Dr. Kingsbury the following message on the same telephone encounter record:

> [I] called in the vicodin to pt's pharmacy, however the pharmacist Janet is uncomfortable and unwilling to fill prescription because pt. is at toxic level. he has picked up hydrocodone these following days #180 7/11, 7/28, 8/16, 8/3, 9/14, 9/29, 10/11, 10/22, 10/28 and now i called in with increase dosage of vicodin. please advise.[9]

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[8] "ST" were the initials of Dr. Kingsbury's medical assistant.

[9] The parties spent a considerable amount of time presenting testimony regarding whether it was reasonable for Dr. Kingsbury to expect the pharmacist to notify him if refills were being sought earlier than Dr. Kingsbury intended. However, based on this message, Dr. Kingsbury knew, as of November 21, 2011, that the patient

Dr. Kingsbury responded at 12:17:38 p.m. that day on the same telephone encounter record:

> [U]nderstood - the patient has made a verbal contract with me TODAY to reduce his vicodin intake over the next few months. He will see me shortly for his physical exam. The problem is being addressed. Tell them we authorize the vicodin as we ordered. Tell them no refills, give #240.

20. According to CURES, the pharmacy dispensed 240 Vicodin tablets to the patient on November 21, 2011, and dispensed another 180 tablets of Vicodin, less than 30 days later, on December 12, 2011, also prescribed by Dr. Kingsbury. Although Dr. Kingsbury stated on November 21, 2011, that he did not authorize any refills, there was nothing in Dr. Kingsbury's medical records for this patient regarding authorization of the 180 Vicodin tablets dispensed to the patient on December 12, 2011.

21. The patient saw Dr. Kingsbury for an examination on December 20, 2011. The Progress Notes for that office visit stated the following under HPI (History of Present Illness): "more stresses, has to go back to work - (out of money)," "takes the hydrocodone for the cough, currently tapering it to reduce overall use," and "took 10 of the vicodin today." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The list of medications the patient was taking included: "Hydrocodone-Acetaminophen 5-500 MG Tablet 4tabs up to 10tabs a day." Under

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had been obtaining monthly supplies (then in 180 tablet quantities) of Vicodin from the pharmacy in two to three-week intervals from July 11, 2011, through November 21, 2011.

"Plan," there was a subheading for "**2. Hepatitis C without hepatic, not otherwise**" (Bold emphasis in original) which included the following notation: "strict warning about reducing Tylenol intake - 8/d max for vicodin (should be less in the next couple weeks)."

JANUARY 2012 THROUGH SEPTEMBER 23, 2012

22. According to CURES, the patient obtained another 180 tablets of Vicodin on January 19, 2012 (four days before his next appointment on January 23, 2012), prescribed by Dr. Kingsbury, but there was no notation in the medical records regarding this prescription being given to the patient.

23. The patient next saw Dr. Kingsbury on January 23, 2012. The Progress Notes stated under HPI: "sleeping well," "to start work in sales again, feels well, now wants 3 vicodin," and "fasting, wants some lab work - wants to check liver function." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The medications being taken included: "Hydrocodone-Acetaminophen 5-500 MG Tablet 2-3tabs qd." The Progress Notes for this office visit did not say anything about tapering off the Vicodin.

24. The CURES report showed that the patient obtained 30 zolpidem (10 mg) prescribed by Dr. Kingsbury on January 24, 2012. However, there was no indication in the Progress Notes for the January 23, 2012, office visit that zolpidem had been a medication the patient was taking or that it had been prescribed. Additionally, although Dr. Kingsbury testified that he prescribed zolpidem to the patient for insomnia, the January 23, 2012, Progress Notes did not indicate the patient suffered from insomnia and instead stated, "sleeping well."

25. The patient saw Dr. Kingsbury again on February 3, 2012, for a follow up after an emergency room visit due to a syncopal (fainting) episode. The Progress Notes for that visit stated that the patient was "sleeping well," and did not include Vicodin or zolpidem on the list of medications being taken by the patient. Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

26. The patient had another office visit with Dr. Kingsbury on February 8, 2012. The Progress Notes for that visit said the patient was "sleeping well," and did not mention zolpidem. Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The Progress Notes also stated that the patient was taking "Hydrocodone-Acetaminophen 5-500 MG Capsule 1 capsule as needed for pain Orally every 6 hrs." Similar language was included under the "Plan," but there was nothing stated about tapering anywhere in the Progress Notes for this visit.

27. According to the CURES report, another 30 zolpidem pills, prescribed by Dr. Kingsbury, were dispensed to the patient on February 18, 2012, and another 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on March 1, 2012.

28. On March 14, 2012, the patient called Dr. Kingsbury's office asking that zolpidem and Vicodin prescriptions be faxed to Walmart, and Dr. Kingsbury's written response on the telephone encounter record was "done."

29. The CURES report did not show any medications dispensed by Walmart, but it showed that the Rite Aid Pharmacy that usually filled the patient's prescriptions dispensed 30 zolpidem to the patient on March 14, 2012. There was no record in the CURES report that the patient filled a Vicodin prescription on or near March 14, 2012.

The CURES report also showed that another 30 zolpidem tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on April 9, 2012.

30. The patient's next office visit was on April 25, 2012. The Progress Notes stated the patient was "sleeping well." There was also a notation that "labs done 4/13 and ast/alt and alk phos elevated."[10] Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." The medications being taken included: "Hydrocodone-Acetaminophen 5-500 MG Capsule 1 capsule as needed for pain Orally every 6 hrs" and "Zolpidem Tartrate 10 MG Tablet take 1 tablet by mouth at bedtime if needed for insomnia." Nothing was mentioned about tapering.

31. According to the CURES report, 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on May 4, 2012, and 30 zolpidem tablets, also prescribed by Dr. Kingsbury, were dispensed on May 6, 2012.

32. During April and May 2012, the patient was seen by an Ear Nose and Throat (ENT) specialist due to chronic sinusitis and surgical intervention was recommended. On May 24, 2012, the patient had sinus surgery. Later that day, the patient left a telephone message for Dr. Kingsbury at 6:30 p.m., reporting that he had sinus surgery that day and he was in a lot of pain. The message stated the surgeon had given the patient amoxicillin, "but no pain meds and no sleeping pills left." At 6:42:08 p.m. that day, under "Action Taken," Dr. Kingsbury wrote: "called in vicodin

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[10] Alanine transaminase (ALT), aspartate transaminase (AST), and alkaline phosphatase (ALK phos) refer to lab work performed to check the patient's liver function.

#30; he has to pay cash. He got #180 on the 4th of May per pharmacist; also he got #30 zolpidem 5/4, so he can't have more of those."[11]

33. On June 4, 2012, Dr. Kingsbury received another message that: "Pt called and states that he would like to speak to you about the [*sic*] his meds. Pt is having a hard time sleeping and is really going through a hard time. Could you please call him?" Dr. Kingsbury wrote the following under "Action Taken" that day:

> [L]ots of pain w recent sinus surgery – can't sleep – "detoxing" from "all those drugs" – not taking vicodin not working, "over the worst" of the pain – no pain meds, due to "heart to heart" with his girlfriend *called in alprazolam[12] .5 mg 1 qhs prn insomnia #20 w 1 refill, to use 4-5x/week.

34. According to the CURES report, 20 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on June 4, 2012.

35. The patient called complaining of fatigue on June 13, 2012, and Dr. Kingsbury saw him for an office visit the next day. The "Chief Complaints" listed in the Progress Notes for that (June 14, 2012) visit were "Discuss sleep issues/fatigue/pain in feet and legs." Under HPI, it stated the patient was "sleeping well," "Done with the

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[11] The CURES report showed that 30 zolpidem tablets, prescribed by another doctor, were dispensed to the patient on May 25, 2012. Dr. Kingsbury was not then checking CURES, he did not have that information while treating the patient.

[12] This was the first prescription of alprazolam; Dr. Kingsbury ceased prescribing zolpidem once he started prescribing alprazolam.

narcotics now - he's over the need for this," "sleeping better with xanax," "went through serious withdrawal from the narcotics - diarrhea, sweats, poor eating - now better," and "has aches and pains in feet/knees." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin." Included in the list of medications taken were "Xanax 0.5 MG Tablet 1 tablet Orally qhs prn insomnia." Under "Plan" was written: "keep the xanax to 3x/week to avoid dependence - a potential problem for him."

36. According to the CURES report, 20 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on June 23, 2012.

37. On July 12, 2012, the patient called requesting a refill of Xanax. Under "Action Taken," Dr. Kingsbury wrote: ".5mg #30 1 qhs prn insomnia w 2 refills." According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on July 13, 2012; August 7, 2012; and September 1, 2012.

38. On September 17, 2012, the patient called for another refill of Xanax. Under "Action Taken," Dr. Kingsbury wrote: ".5mg #30 1 qhs prn insomnia w 3 refills." According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on September 17, 2012.

SEPTEMBER 24, 2012, THROUGH MAY 7, 2013

39. On September 24, 2012, Dr. Kingsbury received the following message: "Pt is experiencing severe lower back pain, he states it was a birth defect. He would like to speak over the phone or he would like an Rx for hydrocodone. Please advise." Under "Action Taken," Dr. Kingsbury responded: "vicodin #180 w no refills, 1-2 qid prn pain."

40. Dr. Kingsbury testified that when he "reinstituted" Vicodin beginning in September 2012, he tried to be "more judicious" because the number of tablets before November of 2011 had been "quite high" and the patient had struggled to reduce the medication before. Dr. Kingsbury conceded that he was aware that the patient was "very capable of misusing" for reasons "other than pain." Dr. Kingsbury felt that if he restarted the patient on Vicodin, he needed "tighter control" and he also needed to avoid exposing the patient to too much acetaminophen. Dr. Kingsbury, therefore, typically prescribed 180 tablets or less.

41. According to the CURES report, 180 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on September 25, 2012, and 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on October 8, 2012.

42. The patient called for a refill of Vicodin on October 17, 2012. That day, Dr. Kingsbury authorized the refill and wrote the following under "Action Taken":

> I would like to know WHY he is using so many vicodin. He tried so hard to get off of these, succeeded in doing so, now has used one month's worth in 3 weeks. please ask him what is going on and that I'd like to see him here soon if this continues. In the meantime, vicodin 5/500 1 qid prn prin [*sic*] #120 w no refills.

Dr. Kingsbury's medical assistant responded to Dr. Kingsbury's questions later that day as follows: "I spoke with pt, he states they are going out of town for the next couple weeks. He wanted to make sure he had enough to get him by during his vacation."

43. According to the CURES report, 120 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on October 17, 2012.

44. After the patient's September 24, 2012, and October 17, 2012, phone requests, Dr. Kingsbury did not see the patient in person until March 6, 2013. In the meantime, Dr. Kingsbury continued to grant the patient's phone requests for medication refills as follows:

- On November 5, 2012, the patient called again seeking refills. The message given to Dr. Kingsbury that day said: "Pt lost his luggage in the Rome airport which had all his medications, he needs a refill of 3 medications: Naproxen 500 MG Tablet, Atacand 32 MG Tablet, Hydrocodon [*sic*] 500mg. He will be reducing his intake of hydrocodone this week." Dr. Kingsbury approved the request, including "vicodin 5/500 1 qid prn #120 w 1 refill." According to the CURES report, 120 Vicodin tablets were dispensed to the patient on November 5, 2012.

- On November 5, 2012, Dr. Kingsbury's medical assistant also scheduled the patient to see Dr. Kingsbury in the office on November 9, 2012; there was no record that the patient was seen on November 9, 2012.

- On November 29, 2012, the patient requested a refill of Xanax for insomnia. Dr. Kingsbury authorized #30 of Xanax 0.5 mg, with three refills. According to the CURES report 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on November 29, 2012.

- On December 18, 2012, Dr. Kingsbury was given the following message: "Pt had intestinal problems for the past week and threw up on his bottle of Xanax. He had to toss 5 of his pills. The pharmacy will not do an early

refill unless we can authorize it 5 days early please advise." Dr. Kingsbury authorized the early refill. According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on December 18, 2012.

- On January 3, 2013, Dr. Kingsbury was given the following message: "Pt would like an rx for hydrocodone he pulled his lower back this afternoon." Dr. Kingsbury's response was "vicodin 1 qid prn pain #60; no refills." According to CURES, the prescription for 60 Vicodin tablets, prescribed by Dr. Kingsbury, was filled on January 3, 2013.

- According to the CURES report, 30 alprazolam tablets, prescribed by Dr. Kingsbury, were dispensed on January 11, 2013, and again on February 3, 2013.

- On February 12, 2013, Dr. Kingsbury received the following message: "I scheduled an appt for the pt to be seen today, he is requesting pain medication for his back. He called to cancel because he feels it's an unecessary [*sic*] hassle to come in on his day off. Pt states his back pain is from a genetic back disorder. Please advise." Dr. Kingsbury authorized "vicodin 1 qid prn pain #120, 1 refill." Dr. Kingsbury also asked his medical assistant, "I'm unclear on his genetic back disorder - please get the name of this disorder and document here, back to me." His medical assistant responded: "Congenital birth defect born with club foot. R leg is shorter than left. His spine is not centered in the pelvic arc. He says from time to time it goes out. He doesn't know the proper name or diagnosis." According to the CURES report, the patient filled the prescription for 120 Vicodin tablets, prescribed by Dr. Kingsbury, on February 13, 2013.

45. Dr. Kingsbury had a six month follow up appointment with the patient on March 6, 2013. The Progress Notes stated the following under HPI: The patient was "sleeping well," "doing well - working happily," "was in a goKart [*sic*] crash last week - feels he needs more narcotic," "reported birth defect in his back - born w club foot - so back is bad off/on through life," and "stress on the job - started 3 months ago." Under "Medication Review," after "Patient administrates medications as prescribed," it stated, "Yes." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

The Progress Notes for that visit also included a "Pain Screening" which provided:

> Patient has a complaint of acute or chronic pain: Yes, Location of pain: Back, Intensity of pain (scale of 0-10): 5, Treatment or medications used to manage pain: NSAIDs, Opioids, Level of relief that the pain treatment has provided: 75%, Pain has interfered with the following: Mood, Sleep, Enjoyment of Life, Plans/Goals/Treatment/Intervention/Follow up: See Plan.[13]

The Progress Notes included the following as the medications the patient was taking: "Alprazolam 0.5 MG Tablet take 1 tablet by mouth at bedtime if needed for sleep" and "Vicodin 5-500 MG Tablet 1 tablet as needed Orally every 6 hrs."

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[13] The "Plan" listed medications, including Vicodin, 5/500 MG, 1 tablet as needed every six hours.

Under "Assessment" was listed:

- LBP [Low back pain] -724.2 (Primary), his primary concern - episodic strains- discogenic dz- stable, treat w PT,[14] narcotics prn
- Drug dependence, combinations excluding opioid type drugs, continuous - 304.81, anxiety and insomnia treated w alprazolam and prn vicodin for pain - stable
- OPIOID DEPENDENCE-EPISOD - 304.02, vicodin/norco use on/off for many years - stable - no changes to vicodin prn and alprazolam for spasm[15]
- Chronic persistent hepatitis - 571.41, biopsy IHSI 2003 - chronic active Hep C - has seen GI in the past (Haynes) - no treatment thought adequate at the time, follow LFTs/Liver synthetic function - stable
- Hepatitis virus C infection - 070.41, chronically elevated ALT and AST, stable - minimize Tylenol products and other s [*sic*] which may irritate liver

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[14] "PT" is an abbreviation for physical therapy. There was no evidence presented regarding whether the patient ever received physical therapy.

[15] This was the first and only time "spasm" was listed as an indication for Xanax.

- Insomnia - 780.52, prn alprazolam/vicodin - stable - no changes

46. According to the CURES report, the patient received 30 alprazolam tablets, prescribed by Dr. Kingsbury, on March 5, 2013.

47. After the March 6, 2013, appointment, Dr. Kingsbury refilled the patient's prescriptions as follows:

- According to CURES, on March 12, 2013, the patient was dispensed 120 Vicodin tablets prescribed by Dr. Kingsbury.
- On April 2, 2013, the patient requested a refill of Vicodin. Dr. Kingsbury authorized "#120 x 1 refill." According to CURES, the patient filled this prescription on April 3, 2013.
- On April 8, 2013, the patient requested a refill of alprazolam. Dr. Kingsbury authorized "#30 w 4 refills." According to CURES, the patient filled this prescription on April 9, 2013.
- On April 22, 2013, Dr. Kingsbury received the following message: "Pt is requesting an early refill of his Hydrocodone. It was last filled on April 3, he is going out of the country on wednesday and will need it. Please advise." The same day the patient also requested a refill of alprazolam because he was going to be in "Vienna for a month." Dr. Kingsbury authorized Vicodin "#120 1 qid, 1 refill" and alprazolam "#30 no refills." According to CURES, the patient filled the prescriptions for 30 alprazolam and 120 Vicodin on April 23, 2013.

MAY 8, 2013, THROUGH JUNE 26, 2013

48. The patient's last appointment with Dr. Kingsbury was on May 8, 2013. The "Chief Complaints" at that appointment were "Suicidal thoughts/depression." The Progress Notes stated the following under HPI: "extremely depressed," "picking at his face a little," "work going poorly and he quit his job last week, uses the vicodin for depression 'makes me happy,'" "his relationship is abusive and he is very unhappy in it," "OK w seeing a therapist," "OK w antidepressant," "30min face to face," "thoughts of suicide but no plan," "contracted for safety and said he would call me if he felt he may follow through, or go to ER." Under "Medical History," the Progress Notes stated: "Cough - responds to vicodin."

The following was written under "Assessment": "Major depressive disorder, recurrent episode severe, without mention of psychotic behavior - 296.33 (Primary)" and "OPIOID DEPENDENCE[16]-CONTIN[17] - 304.01, used for anxiety and depression on pt admission today will taper slowly - 8/day now, scheduled and not PRN 'panic.'"

Under "Plan" was written (bold emphasis in original):

> **1. Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior**

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[16] Dr. Kingsbury explained that "dependence" meant the patient had a physical or psychological need to continue taking the medication and would suffer withdrawal when he stopped taking the medication.

[17] Dr. Kingsbury stated that "CONTIN" meant "continuing."

Start Lexapro Tablet, 10 mg, 1 tablet, Orally, Once a day, 30 days, 30, Refills 3.

Referral To: Psychiatry

Reason: pt occasionally w thoughts of harming self - started on lexapro and xanax today.

2. Others

Continue Vicodin Tablet, 5-500 MG, 1 tablet as needed, Orally, every 6 hrs.

49. According to CURES, 240 Vicodin tablets, prescribed by Dr. Kingsbury, were dispensed to the patient on May 8, 2013. There was no record on CURES that the patient ever filled Dr. Kingsbury's Lexapro (escitalopram) prescription.[18]

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[18] During the hearing, complainant's expert offered opinions regarding Dr. Kingsbury's prescription of Lexapro at the May 8, 2013, office visit. However, the accusation did not provide Dr. Kingsbury notice that his decision to prescribe that medication somehow subjected his certificate to discipline, and complainant did not seek to amend the accusation. The existence of cause to discipline a licensee must necessarily track the specific allegations in the accusation. (See Gov. Code, § 11503, subd. (a), which requires the accusation to "set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his or her defense.") Therefore, only the charges alleged in the accusation are considered in this decision.

50. During the subject interview, when Dr. Kingsbury was asked why he prescribed 240 Vicodin tablets on May 8, 2013, he responded, "I believed that his oral contract with me was satisfactory, and I believed that he would return in two weeks to see me." During the instant hearing, Dr. Kingsbury testified that 240 tablets were "'ridiculous' in the situation" and did "not seem rational." Dr. Kingsbury could not believe he actually prescribed that many, as it would have been twice the number he had previously been prescribing, but he did not have any records to show what he prescribed. Dr. Kingsbury was "baffled" by the number 240; he could not say he did not prescribe that amount, but he could not believe he did.

51. At the time of the May 8, 2013, appointment, a follow up appointment was scheduled for May 22, 2013. However, the patient did not show up for the May 22, 2013, appointment. Dr. Kingsbury's office left messages for the patient that day and set another appointment for June 5, 2013.

52. On June 26, 2013, the Orange County Coroner's office contacted Dr. Kingsbury and notified him that the patient had been found dead of suspected suicide on May 20, 2013. Dr. Kingsbury wrote the following on the June 26, 2013, telephone encounter under "Action Taken": "[Patient] found dead 5/20, suspected suicide in Orange County, from OD. Empty pill bottles w my name found at scene. One bottle (unk med) w Dr. Tadros' [*sic*] name. Records reviewed in detail. [Patient] had apparently seen Dr. Tadros of psychiatry one time prior to death." According to the Coroner's report, the patient's cause of death was "[a]cute citalopram, hydrocodone, alprazolam and clonazepam intoxication."

Dr. Kingsbury's Written Summaries

53. As requested by Consumer Services Analyst Erika Calderon, Dr. Kingsbury prepared a written summary, dated April 5, 2018, which appeared to track the medical records. At the end of the summary, he described his reaction to the patient's death, reflected upon his treatment of the patient, and listed changes he had made in his practice as a result of what happened:

> The death of Mister [Patient] was quite a shock to me and my staff. He had been a valued client of my medical practice for 10 years. I knew he was a troubled soul and had a lot of anxiety and depression in addition to his pain and addiction. Though it is not always reflected in the record, we often spoke of his personal issues and potential solutions, knowing the drug abuse made it more difficult to treat the anxiety and depression. As I look back through the records I can certainly see areas where I could have intervened in a more beneficial way for him. Mr. [Patient] needed more help for his problems. As a consequence of his difficult course and eventual demise we made many changes in the way we prescribed narcotics alone and in combination with benzodiazepines. I maintain a tremendous amount of respect for hydrocodone's addictive potential. Shortly after his death we created our Narcotic Medication Agreement which I have included with the records for your review. We also developed an Opioid Analgesic Medication Information handout so that clients

> can better understand the use of narcotics and their potential side effects. It also became state law that we could no longer prescribe refills for hydrocodone containing narcotics, which added tremendous safety value to our patients requiring opioids. Refills could no longer be filled by patients independent of their physicians writing a new prescription. Pharmacies have also become far more helpful by not refilling restricted medications early without a discussion with me first. We have since made it a requirement for all patients on narcotics to see me every other prescription in the office without exception. They don't like it but they are far safer because of it.

54. Dr. Kingsbury wrote another summary, dated November 20, 2018 (the same day as his subject interview). That summary went into detail regarding why Dr. Kingsbury believed he succumbed to the patient's requests for medication and Dr. Kingsbury's regrets for doing so. Dr. Kingsbury wrote (emphasis in original):

> The medical records of Mr. [Patient] reflect that I prescribed him hydrocodone and alprazolam in the course of managing his medical problems over the course of 10 years. The records also reflect a variety of successful attempts on his part to manipulate me into providing him more of these medications than originally intended. His persistence wore me down and I prescribed his medications in a manner I regret. In review of the records, I can see I felt I had control when clearly I did not. He was charismatic, intelligent and

well spoken, and I gave him the benefit of the doubt too often.

I understand that my documentation could certainly have been better - I could have clarified my thought process and recorded my prescriptions and dates more completely . . . .

I believe the record demonstrates that I cared for this man and his well being and function were my primary concerns. I made attempts to limit and wean the habit-forming medications, utilized antidepressants and anti-anxiety measures and discussed this with him in the office and over the phone. We discussed counseling, physical therapy and other specialties several times, but it's not evident in my documentation until May 2013.

Initially I was treating his back pain - I reviewed his cervical spine disease documented on xray, have been trained to know that low back pain is a common condition and doesn't require imaging to treat briefly with Tylenol, NSAIDs and potentially opiates. I was aware of his history of IVDU and opiate dependence and understood that, once conditioned to opiates, an addicts' [*sic*] pain pathways are forever altered, and responses to the usual doses of narcotics will be suboptimal. This can lead to higher need for narcotics when faced with pain and sobriety, and I felt this was the case with him. When his behavior turned suspicious and manipulative, I limited prescriptions and

attempted weaning, but maintained his prescriptions to prevent withdrawals and preserve his best function. Once again, I felt I had things under control.

[¶] . . . [¶]

I have extensive experience with a broad spectrum of acute and chronic pain in the hospital as an attending physician on the teaching faculty, and in my own clinic. I am experienced with the medications used to treat and maximize function. In my work in the Behavioral Health Unit at Scripps Mercy Hospital I see all kinds of psychiatric illness; anxiety, depression, personality disorders, alcoholism, drug abuse and addiction, and pain medication seeking behavior as well. I have always been drawn to care for these individuals, and have felt I had something to offer them.

Often a person who has chronic pain, a personality disorder, anxiety and depression can be seen as a time-consuming, difficult patient, where the emotional cost and the amount of time necessary to find physicians who will give them the time they need, and so, often I feel obliged to have this be me. Often I have made referrals to pain management physicians, and when my patients don't respond to procedural interventions they wind up back with me. I maintain these clients because I feel I have to; it's my obligation to them.

[¶] . . . [¶]

> Chronic pain and opiate dependence remain a small part of my current medical practice. These patients are the most emotionally challenging for me, as my level of suspicion for abuse must always remain high, and drug dependence is always a part of the equation. They require an individualized approach.
>
> I did not demonstrate an ability to set limits and enforce rules consistently with Mr. [Patient].

Expert Opinion Testimony

55. Complainant called Robert M. Franklin, M.D., as an expert witness and his 32-page December 2, 2018, report was received as evidence without objection. Dr. Franklin's assignment in this case was to review the patient care Dr. Kingsbury provided, assess whether Dr. Kingsbury departed from the standard of care, and, if so, determine whether the departures were extreme or simple departures. Dr. Franklin reviewed all the medical records, the CURES report, Dr. Kingsbury's written summaries, and Dr. Kingsbury's subject interview testimony in order to render his opinions.

56. At times during his testimony as well as in his report, Dr. Franklin seemed to take on the role of an advocate and was quite zealous in the manner in which he articulated his opinions, including employing unnecessarily inflammatory and argumentative language.[19] He also admitted on cross-examination that he purposely

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[19] For example, he described his own reactions to certain facts using words such as "flabbergasted" and "stunned"; he described some departures from the standard of

included language in his report to influence the level of discipline, even though he was cognizant that analyzing the appropriate level of discipline was outside the scope of his assignment and should be left to the trier of fact. Therefore, while evaluating Dr. Franklin's opinions it was necessary to set aside Dr. Franklin's at times overzealous and inflammatory language, and no consideration was given to his statements geared toward a determination of the appropriate level of discipline. Additionally, Dr. Franklin opined that certain statements made by Dr. Kingsbury during the 2018 subject interview were themselves separate departures from the standard of care. Dr. Franklin interpreted those statements to mean that Dr. Kingsbury failed to accept responsibility in 2018 for what happened in 2012 and 2013, and he opined that the *sole* act of making such statements constituted departures from the standard of care. Such opinions were excluded at the hearing, and to the extent such opinions were espoused in Dr. Franklin's report, they were not considered when rendering this decision.[20]

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care as "deadly," "lethal," fatal," and "homicidal"; and he blamed Dr. Kingsbury for the patient's decision to commit suicide based on a Blackbox warning for Lexapro which only applied to young adults under age 24, even though the patient was 66 at the time of his death and the same warning contained language indicating that there was a reduction in risk of suicide in adults aged 65 and older. Such hyperbole was wholly unnecessary and contrary to Dr. Franklin's assignment to provide dispassionate expert opinions.

[20] Although the Business and Professions Code authorizes imposing discipline on a physician for departing from the standard of care during the treatment and care of a patient, it does not authorize imposing discipline *solely* for respondent's later statements. While such statements may be evidence of a departure during the

DR. FRANKLIN'S EDUCATION AND EXPERIENCE

57. Dr. Franklin is licensed to practice medicine in California and is a Diplomate of the American Board of Family Medicine. He obtained his Bachelor of Arts Degree in Zoology from the University of California at Berkeley in 1986 and his Medical Degree from George Washington University School of Medicine in 1990. He completed his three-year residency at the University of California at San Francisco in Family Practice in 1993. Dr. Franklin then worked as a part-time family physician at Southeast Health Center in San Francisco from June 1993 to December 1994 and as an emergency department physician at St. Luke's Hospital in San Francisco from December 1991 to April 1999. He has worked as a family physician at Southeast Health Center in San Francisco since January 1995 and as an emergency department physician at Kaiser Hospital in South San Francisco since September 1997. Dr. Franklin has treated patients with liver damage, opioid dependence, and addiction to alcohol and drugs.

58. Dr. Franklin has served as a medical consultant reviewing cases for the Medical Board of California since December 2003 and as an expert witness, through American Medical Forensic Specialists, since 2009. He has been an expert witness for complainant in approximately 50 cases, and he has provided expert opinion testimony in about a dozen administrative disciplinary hearings. According to Dr. Franklin, when

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treatment and care, and/or may be weighed by the trier of fact in determining the appropriate level of discipline, there was no authority cited to warrant imposing discipline for making the statements. Furthermore, assessing whether Dr. Kingsbury accepted responsibility for his conduct was outside the scope of Dr. Franklin's role as an expert witness.

he has reviewed cases as a consultant for the board, he has found no departures from the standard of care in the majority of the cases he has reviewed.

SUBSTANCE ABUSE AND ABERRANT DRUG BEHAVIOR

59. Dr. Franklin defined substance abuse as misuse of drugs. Intravenous drug use is the "most severe and dangerous" and alcohol abuse is a common form of substance abuse in our society. Prescribing controlled substances to someone with a substance abuse disorder is one of the most challenging aspects of an office-based medical practice. A person who is actively abusing drugs cannot control their consumption. Someone with a history of opiate use disorder has a higher risk of relapse, and if a person has abused one substance, it is more likely that person will abuse another substance.

60. In Dr. Franklin's report, he explained:

> Before we delve into the morass of departures from the standard of practice that was Dr. Kingsbury's management of Mr. [Patient's] chronic pain and substance use disorder, it is important to highlight the term aberrant drug behavior, defined in the standard above, as it applies to Mr. [Patient's] case. Addiction is difficult to precisely define. Recall that Mr. [Patient] defined his use of Vicodin as an addiction in November 2011. It is simplest to regard addiction as a combination of dependence, tolerance, craving and withdrawal upon discontinuation of, in this case, Vicodin. Misuse of course, is a much more straightforward word. Every time Mr. [Patient] took more Vicodin or more Xanax

than Dr. Kingsbury instructed him to take, he misused those medications. Aberrant drug behavior in Mr. [Patient's] case appears to be limited to misuse and addiction.[21]

STANDARD OF CARE

61. Dr. Franklin generally defined the standard of care as "what a doctor should do in a given clinical situation." He also agreed during cross-examination that the standard of care is the level of care that would ordinarily be exercised by a doctor in the community under similar circumstances. Dr. Franklin used the terms "standard of care" and "standard of practice" interchangeably to refer to the standard of care. According to Dr. Franklin's direct examination testimony, the standard of care applicable to Dr. Kingsbury's treatment of the patient at issue in this case included the board's Pain Treatment Guidelines, but the standard of care required more than was stated in those guidelines.

62. Dr. Franklin defined extreme and simple departures from the standard of care as follows: an "extreme" departure would be something so far from the standard of care that "no doctor should do it" and it could cause "direct damage" to the patient, which "no doctor should do." According to Dr. Franklin, a "simple departure" would be something "not as bad as" an extreme departure.

63. According to Dr. Franklin, the time period at issue for purposes of assessing the standard of care in this matter was from the first time Dr. Kingsbury

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[21] The report included a footnote here, which stated: "Diversion is discussed in the interview. There is no evidence that Mr. [Patient] diverted his medication or received diverted medication, though that may have happened."

prescribed opioids to the patient in 2009 through 2013.[22] According to Dr. Franklin, during that time, the standard of care generally required Dr. Kingsbury to take a history, examine the patient, order required studies and labs, make reasonable assessments based on the data, develop a plan of treatment, obtain client consent, treat the patient's condition as planned, monitor the outcome, and document the treatment and care.

64. Dr. Franklin explained that the standard regarding the use of opioids to treat pain has evolved over the years. From 1990 to 2010, the standard of care required aggressive treatment of pain and there was no ceiling on the dosage of pain medications that could be prescribed. Pain was considered the "fifth vital sign," and physicians were expected to use whatever was necessary to treat pain, including opioids. From 2010 through 2012, the medical community standard started shifting away from using whatever was necessary to treat pain because it was becoming apparent that it was dangerous to prescribe high doses of opioids. By 2012 and/or 2013, "most of us backed away" from treating pain with opioids. By 2016, the Center for Disease Control declared that it was no longer considered safe to prescribe high

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[22] Although Dr. Franklin rendered opinions regarding whether Dr. Kingsbury departed from the standard of care before January 2012, those opinions were not considered in rendering this decision because complainant was barred from seeking to discipline Dr. Kingsbury for conduct that occurred more than seven years before the accusation was filled on January 3, 2019.

doses of more than 50 morphine equivalents per day (1 mg equaled 1 morphine equivalent dose).[23]

65. According to Dr. Franklin, the standard of care has not changed that much. It required Dr. Kingsbury to "do it right"; what was "right" has changed. Dr. Franklin considered the board's Pain Treatment Guidelines as the "floor" of what physicians should have been doing if they were "doing everything okay." The Pain Treatment Guidelines were created "to help doctors comply with the standard of care." But the Pain Treatment Guidelines did not include everything needed to comply with the standard of care.

67. In this case, Dr. Franklin explained that the standard of care required Dr. Kingsbury to do the following when prescribing controlled substances:

- Conduct an assessment of the patient's pain, including an examination and an "assessment of what was wrong."
- Develop a treatment plan that had goals/objectives.
- Document the medical indication for treatment of pain with opioids, including the cause of the pain and the reasons opioids were included as part of the treatment. The physician should not let the "indication morph into different things."

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[23] This was not an issue in this case, as the daily doses of opioids Dr. Kingsbury prescribed the patient were at 20 morphine equivalents or less. Furthermore, according to Dr. Franklin, the amount consumed by the patient when he took more Vicodin than Dr. Kingsbury intended never exceeded 50 morphine equivalents per day.

- Obtain informed consent from the client before proceeding with the plan. The informed consent required would involve a dynamic process between the patient and physician and could be very simple. Informed consent should include a reasonably complete discussion of relevant risks and benefits, and it could be implied. Written informed consent was not required for the prescription of controlled substances.

- Prescribe a limited amount of medication, be acutely aware of the drugs prescribed, and if prescribing to an addict, be "really careful." Physicians should not "negotiate" with an addict; the physician must maintain control of the patient's access to controlled substances.

- Limit the dosage of acetaminophen to no more than 4,000 mg (or 4g) per day for any patient, and no more than 2,000 mg (or 2 g) for a patient with liver disease, such as hepatitis C.

- Conduct periodic review of how the patient was doing with the treatment, including assessing whether the treatment was working and noting any red flags, such as early refills, past addiction, and/or withdrawal symptoms. A physician may want to alter the course of treatment and consider alternative treatments.

- Diligently look for signs of abuse and aberrant drug use. Every time the doctor saw the patient, it was important to consider if the drug was being used to "good effect."

- Respond in an organized way if abuse or misuse was detected. If a patient was obtaining early refills and the pharmacy notified the doctor, then the doctor would need to act upon that. When aberrant drug

behavior was detected, the physician needed to stop it. There was "no wiggle room." The easiest way to stop would be to stop prescribing, but that may not be the best thing to do. A physician could start seeing a patient weekly and involve the pharmacist and the family. A physician could taper the use of the medication by reducing the dose. Typically, a "rapid" taper would involve reducing the dose by 10 percent per day, but it could be per month.

- Consultation with others if the physician was not capable of rendering the care. In the treatment of pain, consultation could be a series of emails with a pain group, referral to specialists, and/or calling a specialist.

- Additionally, the standard of care precluded office-based use of opioids to treat opioid addiction.

- Accurately document everything in the medical records, because "if it was not in the chart it did not happen." The medical records needed to be complete and accurate so they would show what was being done and why. Every prescription must be clearly documented, including "what it was for" and "how long it was for." It was the community standard to write every prescription in the progress notes with a next refill date. Then the physician could see if the patient was seeking early refills. The standard of care required the physician to have control over the drugs being prescribed and it was not possible to do that if the prescriptions were not adequately documented. It was also possible to clearly write

"quantity sufficient until" a specific date on prescriptions so that the pharmacist would know not to give a refill before that date.[24]

- Sign and date the medical documentation within a reasonable time.

DEPARTURES FROM THE STANDARD OF CARE

68. Dr. Franklin determined that Dr. Kingsbury engaged in numerous extreme departures from the standard of care; several simple departures from the standard of care; that he demonstrated a lack of knowledge during his treatment and care of the patient; and that his medical record keeping was deficient in multiple respects.

Extreme Departures from the Standard of Care

69. Dr. Franklin opined that Dr. Kingsbury's care and treatment of the patient amounted to several extreme departures from the standard of care. His hearing testimony tracked his report, which provided[25]:

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[24] Because the prescriptions were not offered as evidence and the progress notes did not state such language was used, there was no evidence that Dr. Kingsbury used such language on the prescriptions at issue here.

[25] Although complainant argued that there were over 100 such departures, it is worth noting that Dr. Franklin's list of extreme departures overlapped, was repetitive, and included departures outside the statute of limitations because they occurred more than seven years before the filing of the accusation. While the nature and extent of the departures from the standard of care were important, the specific number of departures was not determinative of the conclusions reached in this decision.

- "Dr. Kingsbury's management of Mr. [Patient's] pain, anxiety, depression, and substance use disorder" was a series of extreme departures, "culminating in the prescription of 480 tablets of Vicodin 5/500 in the 35 days up to and including the last visit with the patient. Such a massive over-prescription of controlled medication to a man with known liver disease, opioid use disorder, and suicidal ideation was an extreme departure from the standard of practice."

- Dr. Kingsbury was over-prescribing opioid to the patient "at least as early as 12/31/10. Every prescription for Vicodin that follows that date represents a separate extreme departure from the standard of practice."

- Dr. Kingsbury's failure to "recognize each red flag for aberrant drug behavior" was a series of extreme departures from the standard of care, and "[e]very early prescription, each excessive prescription, represented such a red flag."

- Dr. Kingsbury's failure "to take decisive action to eliminate Mr. [Patient's] aberrant drug behavior" was a series of extreme departures from the standard of care.

- "It was an extreme departure from the standard of practice to fail to immediately taper and discontinue Vicodin on 11/21/11 when he described himself as addicted to Vicodin. Every prescription for a controlled [*sic*] issued on or after 11/21/11 represents a separate extreme departure from the standard of practice, because none of those prescriptions were issued in the course of a rigorously structured taper."

- At the time of the last, May 8, 2013, office visit, Dr. Kingsbury's "apparent belief that Mr. [Patient] was reducing his consumption of Vicodin at a time when Dr. Kingsbury prescribed 480 tablets in 35 days" was an extreme departure from the standard of care.

- Dr. Kingsbury's failure "to document the detailed historical and physical findings that supported treatment of Mr. [Patient] with opioids and benzodiazepines" was an extreme departure from the standard of care.

- Dr. Kingsbury's failure "to document an analysis of the impact on Mr. [Patient's] quality of life of [*sic*] his chronic pain" was an extreme departure from the standard of care.

- "Because of Mr. [Patient's] known history of prior intravenous drug abuse, it was an extreme departure from the standard of practice to undertake to treat Mr. [Patient's] chronic pain with opioid medication without specifically documenting how that treatment was to be done while simultaneously preventing his return to drug addiction."

- "It was an extreme departure from the standard of practice to fail to document a recognized indication for the use of Vicodin in the treatment of Mr. [Patient]. It was a series of extreme departures from the standard of practice to allow the record to be unclear as to whether Vicodin was being used to control pain or to control cough. If Vicodin was indeed being used to control cough, it is and [*sic*] extreme departure from the standard of practice that there is no documentation of why it was used for that 'off label' indication."

- "It was an extreme departure from the standard of practice to fail to perform and carefully document informed consent prior to beginning treatment with opioids in a formerly drug addicted patient."

- "It was an extreme departure from the standard of practice to fail to carefully document a specific treatment plan with measurable benchmarks for the use of opioid medication. It was an extreme departure from the standard of practice to fail to carefully document the non-opioid pain treatment plan in parallel with the opioid treatment plan."

- "It was a series of extreme departures from the standard of practice to fail to document formal periodic reviews of the safety and efficacy of the treatment of Mr. [Patient] with opioid medication."

- "It was a series of extreme departures from the standard of practice for Dr. Kingsbury not to diligently search out evidence of aberrant drug behavior such as early refills and overuse of controlled medication."

- Once Dr. Kingsbury became aware of the patient's "aberrant drug behavior, self-acknowledged addiction and a pattern of medication overuse," it was an extreme departure from the standard of care to fail to "formulate and document in the medical record a rigorous plan to control that behavior."

- "Dr. Kingsbury's failure to document the fact that in early 2012 he thought he was being manipulated by Mr. [Patient] was an extreme departure from the standard of practice."

- Dr. Kingsbury's failure to refer the patient for treatment of his addiction was an extreme departure from the standard of care.

- "It was a separate departure from the standard of practice to prescribe 240 tablets of Vicodin to Mr. [Patient] rendering the likelihood of a taper to nothing, on the very day when the taper was supposedly instituted."

- "Dr. Kingsbury's failure to take any of the recognized steps that a rational physician would take to ensure that a patient with substance use disorder would safely taper his opioid use is a series of extreme departures from the standard of practice."

- "Dr. Kingsbury's decision to resume prescription of opioids to Mr. [Patient] on 9/25/12 was a life threatening extreme departure from the standard of practice that directly contributed to Mr. [Patient's] renewed abuse of opioids."

- "It was a series of life threatening extreme departures from the standard of practice to overdose Mr. [Patient] with acetaminophen" in 2012 and 2013. Dr. Franklin calculated, based on the CURES information showing the dates and amounts of Vicodin dispensed to the patient, that from January 2012 through May 2013, the patient, who suffered from liver disease, was routinely consuming more than 2,000 mg of acetaminophen.

- "It was an extreme departure from the standard of practice to fail to document a rationale for the prescription of Ambien in the medical record prior to first prescribing it on 1/24/12."

- "It was a separate extreme departure from the standard of practice to fail to include in that documentation a detailed discussion of why and how it was safe to simultaneously prescribe benzodiazepines[26] and opioids to a patient with opioid use disorder."

- With respect to the prescribing of Ambien and Xanax, "[i]t was a series of separate extreme departures from the standard of practice to fail to document the rationale for that treatment plan from 1/24/12 through the final visit in 2013."

- It was a series of "extreme departures from the standard of practice to allow Mr. [Patient] to have access to more than the intended amount of Ambien and Xanax."

- "It was a series of extreme departures from the standard of practice to allow the rationale for the prescription of benzodiazepines to shift and change in the record without a detailed discussion of why that was happening."

- It was an extreme departure from the standard of care "for Dr. Kingsbury to prescribe 240 tablets of Vicodin to Mr. [Patient] on 5/8/13 when Mr. [Patient] reported suicidal ideation" even though Dr. Kingsbury thought his oral contract with the patient was "satisfactory." "Providing a suicidal

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[26] Although Dr. Franklin testified that Ambien is not a benzodiazepine, but a benzodiazepine analog, he grouped Ambien and Xanax, which is a benzodiazepine, together as "benzodiazepines" when rendering his opinions.

patient with a lethal dose of medication, contract or no contract, is . . . an extreme departure from the standard of practice."

- "It was a series of extreme departures from the standard of practice to lock" the progress notes "in 2018 without adding an addendum to the record indicating what was being done and why."[27]

- "It was a series of extreme departures from the standard of practice to prescribe controlled substances for more than 30-day intervals."[28]

- "Dr. Kingsbury's failure to recognize that Mr. [Patient's] primary diagnosis was substance use disorder, complicated by various comorbidities" was an extreme departure from the standard of care.

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[27] Dr. Franklin also opined that if the records were "substantively altered in 2018 before being locked, that was an extreme departure from the standard of practice." However, the accusation did not allege the records were altered and there was no evidence presented that the records were altered. Therefore, that speculative opinion, regarding something which was not alleged in the accusation, was not considered in rendering this decision

[28] There was no evidence presented that Dr. Kingsbury prescribed controlled substances for more than 30-day intervals; Dr. Franklin was clear in his testimony that refills were permitted for the medications prescribed during the timeframe in question.

Simple Departures from the Standard of Care

70. According to Dr. Franklin's testimony, which tracked the opinions in his report, Dr. Kingsbury engaged in the following simple departures from the standard of care:

- "It was a series of simple departures from the standard of practice to fail to document in the medical record the exact quantity and number of refills issued for controlled medications."
- Dr. Kingsbury's "failure to 'lock', to electronically sign, multiple progress notes in a timely fashion" was a series of simple departures from the standard of care.

Lack of Knowledge/Incompetence

71. Dr. Franklin opined that Dr. Kingsbury's decision to continue treating the patient with opioids, with knowledge of the patient's history of drug abuse, and after becoming aware that the patient was misusing the medications, showed Dr. Kingsbury lacked the knowledge to capably care for this patient. In his report, Dr. Franklin wrote:

> In a discussion during the interview of his failure to refer Mr. [Patient] for treatment of his opioid addiction, Dr. Kingsbury states: "I honestly felt that I was well-prepared to take care of this man. I have a lot of diverse training in this area. I have a lot of experience with psychiatric patients of all kinds of pain, acute and chronic. I felt like I was an appropriate physician for him." [Fn. Omitted.] . . . The objective record in this case demonstrates that Dr.

> Kingsbury was not only incapable of treating Mr. [Patient] for his opioid addiction, but was incapable even of limiting the amount of opioids that he personally prescribed to this opioid addicted man. The record therefore proves that Dr. Kingsbury was anything but an "appropriate physician for him." Dr. Kingsbury not only failed to treat Mr. [Patient's] addiction in any way, but he provided the means for Mr. [Patient] to remain addicted. The standard of care does not require an office-based primary care physician to treat addiction. But it does require that physician to refer drug addicted patients for addiction treatment. More importantly, the standard of care specifically requires physicians not to provide chronic opioid medication to opioid addicts, except in the most unusual circumstances, none of which even remotely apply to Mr. [Patient]. While an opioid-addicted patient dying of a painful cancer might reasonably be treated with opioid pain medication, Mr. [Patient] was not dying of a painful condition. He was injuring himself with addiction to opioid medications, prescribed by Dr. Kingsbury variously for cough and ill-defined pain. . . .

72. Dr. Franklin concluded that Dr. Kingsbury's actions when, and continuing after, he initiated the plan to taper the patient from his Vicodin use beginning November 21, 2011, demonstrated a lack of knowledge in a number of respects. The manner in which Dr. Kingsbury instituted the taper, including prescribing 240 tablets of Vicodin, showed a "lack of knowledge of substance abuse disorder." Dr. Franklin also

opined that Dr. Kingsbury's note on October 17, 2012, asking "' WHY he is using so many Vicodin'" was "evidence of inexplicable lack of knowledge" because Dr. Kingsbury was "asking why drug addicts abuse the drugs to which they are addicted. The level of lack of knowledge represented by that question is hard to comprehend."

73. Similarly, Dr. Kingsbury opined that Dr. Kingsbury's feeling that "he 'had things under control' at the 5/8/13, the final visit . . . represents a stunning lack of knowledge," and his "apparent belief that Mr. [Patient] was reducing his consumption of Vicodin at a time when Dr. Kingsbury prescribed 480 tablets in 35 days" was an extreme departure from the standard of care. Dr. Franklin noted in his report that "[t]he combination of these extreme departures from the standard of care and appalling lack of knowledge casts doubt on Dr. Kingsbury's ability to learn how to practice medicine safely, as it relates to the prescription of controlled substances." "Dr. Kingsbury's thought that 'his oral contract with me was satisfactory'" was "representative of profound, deadly lack of knowledge."

74. Dr. Franklin testified, and wrote in his report, that Dr. Kingsbury's "failure to recognize" that the patient's "primary diagnosis was substance use disorder, complicated by various comorbidities" was both an extreme departure from the standard of care and represented a lack of knowledge. "His belief that he was well-prepared to take care of Mr. [Patient] represents lack of knowledge." The fact that Dr. Kingsbury believed "he limited Mr. [Patient's access to Vicodin in the face of the documented fact that he overprescribed Vicodin from 9/25/2012 forward," represented a lack of knowledge because Dr. Kingsbury did "not know what it means to limit access. The fact that he failed to recognize that opioid use disorder is a chronic problem that contraindicates the chronic outpatient prescription of opioid medication is reflective of" lack of knowledge.

75. Dr. Franklin testified and wrote in his report that the fact that Dr. Kingsbury was surprised that pharmacists refilled prescriptions sooner than in 30-day intervals demonstrated a "lack of knowledge" that pharmacists may "refill prescriptions at earlier than 30-day intervals unless there is a specific written order not to do so." During his hearing testimony, Dr. Franklin went so far as to state that "everyone" in the medical community knew during the 2012 and 2013 timeframe that pharmacists were inappropriately dispensing refills earlier than they should.[29]

Discrepancies in the Medical Records

76. During Dr. Franklin's testimony and in his report, he listed Dr. Kingsbury's failures to document important information in the medical records of the patient as required by the standard of care:

- An adequate history of the nature of the patient's pain and its effect on the patient's quality of life was not well documented. Dr. Kingsbury did not document an analysis of the pain and its effect on quality of life, which would usually be "framed in terms of what the patient is unable to do because of pain."

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[29] Although Dr. Kingsbury may have made a point that physicians should have been able to rely on pharmacists not to dispense early refills, the fact that the pharmacist notified him on November 21, 2011, that this patient had been dispensed monthly supplies of Vicodin in two to three-week intervals seriously undercut that argument and showed that Dr. Kingsbury was on notice that pharmacists had given this patient early refills.

- The patient's psychiatric complaints were not well documented "particularly in early 2012 when treatment with zolpidem was undertaken."

- Although a history of substance abuse was clearly documented, "critically absent, from the record is a discussion of precisely how Dr. Kingsbury planned to prescribe this former intravenous drug addict controlled medication in a safe and effective manner, without allowing him to relapse into addiction."

- "Dr. Kingsbury did not document a recognized indication for treatment with opioid medications."

- "[T]he medical record does not include a discussion of exactly what pain is under treatment and exactly how that pain is being evaluated."

- Dr. Kingsbury's documentation did not describe "for what, exactly, Vicodin is prescribed. The documented medical history includes 'Cough - responds to Vicodin'. Yet of course Vicodin is not indicated as a treatment for chronic cough."

- "The multiple and changing justifications offered for treatment documented in the medical record reflect the absence of a rational assessment of Mr. [Patient's] pain."

- Informed consent to treat the patient with opioid medication was not documented.

- "Specific treatment goals are not documented" and "[a]lternative treatment modalities are not well-documented."

- There was "[n]o careful documentation of the effectiveness or safety of ongoing treatment of Mr. [Patient] with opioid medication."
- "[I]t was not possible from the record to determine the exact quantity and timing of controlled substances."
- The medical record "was not managed appropriately: multiple progress notes were not electronically signed until April 2018."
- There was no "clear indication for the prescription of benzodiazepines to Mr. [Patient]. Through the course of the chart, the indication varies. Sometimes it is insomnia. Sometimes it is anxiety. At one visit it is muscle spasm."
- Although the CURES reports showed that Ambien was prescribed beginning in January 2012, it was not mentioned in Dr. Kingsbury's medical records until the patient's request for a refill was noted in a telephone encounter record, dated March 14, 2012.
- The progress notes stated the patient was sleeping well, which contradicted the indication for medication to help with insomnia.
- "There is no discussion at all in the medical record of the dangers of prescribing the commonly lethal combination of opioids and benzodiazepines to a patient suffering from opioid use disorder."

Dr. Kingsbury's Hearing Testimony

77. During his hearing testimony, Dr. Kingsbury did not deny that he failed to appropriately treat and care of the patient or that his record keeping was inadequate.

He acknowledged responsibility for his conduct and expressed his shame, humiliation, and remorse. His testimony was sincere and direct.

78. Dr. Kingsbury admitted that by 2011 he knew the patient was misusing his medications and manipulating him. When Dr. Kingsbury was notified by the pharmacy of the early refills on November 21, 2011, and based on what the patient told him the same day, Dr. Kingsbury was "very concerned about it," and "it was clear" that the patient "was not using" the medications "as intended." Dr. Kingsbury then knew the patient needed to slow down and needed to come off the Vicodin slowly. So, Dr. Kingsbury tried to carefully reduce the patient's consumption at that time. Dr. Kingsbury also gave the patient a "strict warning" on December 21, 2011, that if he went above 4 g per day of acetaminophen it would damage his liver and he needed to bring it down. After the patient reported on January 23, 2012, that he was down to 3 Vicodin per day, Dr. Kingsbury thought things were under control as of February or March of 2012. When Dr. Kingsbury was asked whether he ever considered prescribing a pain medication that did not contain acetaminophen, he could not recall if he did, and then stated that he "definitely should have."

79. Dr. Kingsbury acknowledged that there were red flags of aberrant drug use which included the patient's claims that he had lost medications, vomited on medications, needed extra medication because he would be out of the country, lost luggage containing medication, and needed medication for a club foot and due to a Go Kart accident. Dr. Kingsbury stated that "in retrospect" he realized these were "all lame excuses to get pills." The patient's girlfriend also spoke with Dr. Kingsbury twice about her concerns. Looking back, Dr. Kingsbury recognized that the patient was not being "genuine" with him.

80. Dr. Kingsbury described his relationship with the patient as "push me pull me." Dr. Kingsbury sometimes felt "uncomfortable" with the patient, who he described as charming, well-spoken, and a decent communicator. Although Dr. Kingsbury may have thought at the time that he had some control, he acknowledged during his hearing testimony that "obviously" he was "not offering any resistance to the requests." Dr. Kingsbury realized he was "too easily manipulated" and he "didn't have the proper perspective." He did not have "check points" to "neutralize" his own reaction to the patient. According to Dr. Kingsbury, "mostly," the patient was able to "get under" his "skin." Something "appealed" to him about the patient, as Dr. Kingsbury has a "soft spot for troubled souls." Often such patients are "difficult to deal with," "lots of doctors don't want to deal with them at all," and they are "difficult to control." Dr. Kingsbury acknowledged that he was aware the patient was not using the Vicodin for pain. At the time, Dr. Kingsbury felt that, with his experience with the Behavioral Health Unit, he was a "good fit" to treat this patient. But at the time of the hearing, Dr. Kingsbury no longer felt that way. Dr. Kingsbury conceded that he was "unable to set limits" with the patient, and he "wished" he had referred the patient to a specialist earlier.

81. The purpose of tapering the patient off Vicodin during 2013 was to help the patient avoid withdrawal symptoms because the patient had previously suffered severe withdrawal symptoms. The patient expressed the desire to get off the narcotics, and Dr. Kingsbury "did not want him to experience a lot of negativity." As of May 8, 2013, Dr. Kingsbury "needed to act" and to "avoid" the patient acting on his suicidal thoughts.

82. Dr. Kingsbury also testified that he had "overstressed the importance of withdrawal response." He "overemphasized the risk of withdrawal" and was "nervous"

about cutting the patient completely off the medication. Looking back, it was not a reasonable way to handle it, making Dr. Kingsbury's current situation "quite humiliating" and "embarrassing." Dr. Kingsbury stated that he did not "know how this happened"; he did not have the information available, because of the way his medical records were written, "to even figure out" why he handled the situation the way he did. He "let the patient manipulate" him.

83. During Dr. Kingsbury's training and residency, he was not instructed to check with the pharmacy to see if a patient was seeking or receiving early refills. He was not aware pharmacies were filling prescriptions early. He never heard that the standard of care required him to make inquiries to the pharmacy, and he was surprised when he learned the pharmacy had dispensed early refills, as he would have expected the pharmacy to call him after the first time. It was also not Dr. Kingsbury's experience that pharmacists were known to dispense medication early; he had never heard of that being a problem from any colleague.

84. Regarding the Xanax and Ambien prescriptions, Dr. Kingsbury stated that his prescriptions would typically say "every night as needed," but that he would coach the patient to use the medication four to five times a week at most to avoid tolerance and to promote efficacy. Therefore, the notations in the medical records about limiting to three to five times a week concerned his verbal instructions to the patient. He also discussed the patient's history of abuse with the patient because Dr. Kingsbury wanted the patient to be careful with his medications and not overuse them.

85. Dr. Kingsbury noted that he was also well aware of the contraindication of Vicodin and benzodiazepines; that both can be sedating and that there was the danger of respiratory suppression.

86. Dr. Kingsbury felt shocked and awful after he learned of the patient's death in 2013. As a result, he thought about what he could have done better, and he wanted to make sure he did the right thing. This was the first and only time something like this had ever happened in his practice. The situation with this patient "squashed" him. Everything had to change. Even though Dr. Kingsbury had a lot of experience dealing with difficult patients and prescribing medications, it "still happened to" him, and it was "shameful."

87. Dr. Kingsbury instituted the following changes to his practice in 2013:

- He required patients treated with narcotics to enter into a "Narcotic Medication Agreement";
- He prepared a pamphlet titled, "Opioid Analgesic Medication Information" that he gave to patients on chronic opioid prescriptions, and he discussed the risks and benefits of such medications with them;
- He began requiring patients on pain medications to see him every other prescription;
- He stopped writing refills for these types of medications;
- He began requiring drug screens once to twice a year depending on the circumstances; and
- He improved his documentation regarding the type of pain, the location of the pain, its impact on activities of daily living, and improvement of function.

88. Dr. Kingsbury acknowledged that his record keeping was below the standards he wanted to meet, and he voiced concern during his hearing testimony because he could not tell what happened regarding certain aspects of his care of the patient from his own records. He described his documentation as "lacking all over the place."

89. Dr. Kingsbury noted changes in the law and medical community that have helped him more safely care for his patients, including:

- Vicodin became a Schedule II controlled substance in 2014 so refills were no longer allowed;
- The CURES system has gotten less laborious to use; and
- Since 2016, the law changed, mandating that he check CURES before each new prescription and then quarterly, which he has been doing as required.

90. After the accusation was filed, Dr. Kingsbury attended UCSD's School of Medicine Continuing Medical Education Medical Record Keeping Course on May 2 to 3, 2019, and Physician Prescribing Course on January 14 to 16, 2019.

91. Dr. Kingsbury noted that patients can still be disingenuous with him. "But there are more checks in place along the way" so he "can pick up on it earlier." If Dr. Kingsbury encountered a similar patient now, he believed he would handle the situation differently, including:

- If the patient wanted narcotics, he would not prescribe them at all, or it would be harder to get him to prescribe them;

- If the situation looked complex and he felt the "vibe" of being used, he would at least get another doctor to review the case with him;
- He would document better;
- He would be more controlled in his prescribing;
- He would still need to be on guard, but there are now other things, such as changes in the law, that would help him maintain better control;
- Dr. Kingsbury also started using a new system called "Electronic Prescribing Controlled Substances (EPCS)" that allows him to see every prescription and refill in real time. This system, which he described as very "lock step," makes it more difficult to overprescribe because he can see when prescriptions are dispensed through CURES.

Character Evidence

92. Dr. Kingsbury called to two character witnesses, Laurance Davis Cracroft, M.D., and Howard Williams, M.D., both of whom have known Dr. Kingsbury since he started his internship in 1996 at Scripps Mercy Hospital. Both Dr. Cracroft and Dr. Williams wrote glowing reference letters, which were received in evidence as administrative hearsay and supplemented and explained their hearing testimony. (Gov. Code, § 11513, subd. (d).)

93. Dr. Cracroft practiced emergency medicine at Scripps Mercy Hospital from 1978 until he retired in December 2018. Dr. Cracroft did not socialize with Dr. Kingsbury, but he said they had become friends "as much as that is allowed." Dr. Cracroft helped trainDr. Kingsbury when he was an intern at Scripps Mercy approximately 23 years ago. Over the years, Dr. Kingsbury has called the emergency

department to admit patients while Dr. Cracroft was working there. Dr. Cracroft also noted that Dr. Kingsbury had been part of the training faculty and worked in the Behavioral Health Unit at Scripps Mercy Hospital. Dr. Cracroft said Dr. Kingsbury did a "great job" as a teacher at the hospital.

Dr. Cracroft also served for over 20 years on the Quality and Credentialing Board at Scripps. Any doctors with any limitations in ability were brought before that board, and Dr. Kingsbury has never been among the doctors that were scrutinized.

Dr. Cracroft was aware of the accusation, but he only knew a "general outline" of the charges. He did not know the details of the patient care provided, other than that it concerned narcotics and that the patient overdosed to end his life. Dr. Kingsbury asked him to write a letter on his behalf, and before completing it, Dr. Cracroft checked the opinions of some others who had worked with Dr. Kingsbury. Because they all praised Dr. Kingsbury, Dr. Cracroft felt confident writing his letter after speaking with them.

In his June 12, 2019, letter, Dr. Cracroft wrote the following:

> I have had the pleasure of working closely with Grant Kingsbury, MD, at Scripps Mercy Hospital for over 23 years. In my varied roles as an emergency physician, chair of the emergency department, previous chief of staff, and longstanding Scripps Mercy Senior Medical Director, I have frequently interacted on many levels with Grant during his career at Scripps Mercy Hospital. . . . Throughout this time his personal and professional interactions with staff and patients have been exemplary. Grant is a dedicated care

> giver, a superb clinician, and an accomplished teacher. Since completing his residency Grant has continuously served as a distinguished member of our teaching faculty. . . .
>
> . . . Though the stress can on occasion be palpable in our inner city, high acuity hospital, Grant always remains cool and controlled even under the most intense situations. Grant always demonstrates the highest ethical standards; he is honest, straightforward, and fair in his dealings with others.

94. Dr. Williams operates a private internal medical practice in the same medical office building where Dr. Kingsbury works. They are both members of Mercy Physicians Medical Group (MPMG), which is an independent practice association (or IPA). They see each other regularly at IPA meetings and in the building, although they do not socialize.

According to Dr. Williams, Scripps Mercy Hospital is a well-known quality learning institution that attracts good interns and residents, and Dr. Kingsbury was in the top quarter of his class when he trained there. Scripps Mercy oversees all its physicians and requires that they all to be recertified every two years. Dr. Williams was not aware of any problems with Dr. Kingsbury at the hospital.

Dr. Williams described Dr. Kingsbury as conscientious, hardworking, a quick learner, and a good physician. Dr. Williams has regularly referred patients to Dr. Kingsbury. Dr. Williams considered Dr. Kingsbury to have an "excellent" character for honesty and truthfulness. Dr. Williams also noted that Dr. Kingsbury was among the "Top Docs" listed in San Diego Magazine's May 2012 issue.

Dr. Williams saw the accusation and discussed it with Dr. Kingsbury. Dr. Williams noted that it was "not a good reflection of" Dr. Kingsbury's "style," and he had never seen a similar example.

In his March 24, 2019, letter, which he re-signed at the hearing, Dr. Williams described Dr. Kingsbury during his three-year internship and residency as "clearly well-educated, hard-working and thoughtful. He was at least in the top quarter of a class that was extremely talented." He also wrote that "[a]fter all I know about his training, his work ethic, his character and the allegations that have been brought forth, I would gladly send a relative to him for medical care."

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of a disciplinary action is not to punish, but to protect the public, and the inquiry must be limited to the effect of the physician's actions upon the quality of his service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) It is far more desirable to impose discipline before a licensee harms any patient than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.)

The Burden and Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (*Martin v. State Personnel Board* (1972) 26 Cal.App.3d 573, 582.)

3. The standard of proof in an administrative action seeking to suspend or revoke a physician's and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

4. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

5. In a disciplinary proceeding, the burden is on respondent to produce positive evidence of rehabilitation. (*Epstein v. California Horse Racing Board* (1963) 222 Cal.App.2d 831, 842-843.)

Statutory Disciplinary Authority

6. Business and Professions Code section 2227 provides:

> (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.

7. Business and Professions Code section 2229 provides:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

8. Business and Professions Code section 2234, subdivisions (a), (b), (c), and (d), provide:

> 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.

(d) Incompetence.

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

Statutory Authority Regarding Prescribing Practices

10. Business and Professions Code section 725 provides:

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

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

for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

11. Business and Professions Code section 2241 states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or

administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

12. Business and Professions Code section 2241.5 provides:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.[30]

[¶] . . . [¶]

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

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[30] Section 2241.5 was amended effective January 1, 2016. The amendment changed only subdivision (c)(3), which included the following language in effect between January 1, 2007 and December 31, 2015: "Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs." The recent amendments to this subdivision concerned recommending medical cannabis, which is not at issue in this matter.

13. Business and Professions Code section 2242, subdivision (a),[31] provides:

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

Statutes of Limitations

14. Business and Professions Code section 2230.5, subdivision (a), provides:

> (a) Except as provided in subdivisions (b), (c), and (e),[32] any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

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[31] The remaining subdivisions of this section include exceptions which do not apply to this case, such as prescriptions given during the absence of the patient's regular physician.

[32] Subdivisions (b), (c), and (e) concern exceptions to the statute of limitations that are not applicable here.

Pertinent Case Law

STANDARD OF CARE

15. The law is well established that "[t]he standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts." (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753.) In *Sinz*, the California Supreme Court explained (*Ibid.*):

> The criterion in this regard is not the highest skill medical science knows; "the law exacts of physicians and surgeons in the practice of their profession only that they possess and exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances." [Citation.] The proof of that standard is made by the testimony of a physician qualified to speak as an expert . . . . He must have had basic educational and professional training as a general foundation for his testimony, but it is a practical knowledge of what is usually and customarily done by physicians under circumstances similar to those which confronted the defendant charged with malpractice that is of controlling importance in determining competency of the expert to testify to the degree of care against which the treatment given is to be measured.

16. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the

same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. [Citations.] The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. [Citations.]" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86; *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; see also, *Borrayo v. Avery* (2016) 2 Cal.App.5th 304, 310-311, regarding formulating the standard of care as that of physicians in similar circumstances rather than similar locations.) A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

17. The standard of care must be provided through expert testimony. (*Sinz, supra,* 33 Cal.2d at p. 753; See also *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215-219.) "The party offering the expert must demonstrate that the expert's knowledge of the subject is sufficient, and the determinative issue in each case is whether the witness has sufficient skill or experience in the field so his testimony would be likely to assist" the trier of fact. (*Id.* at p. 219.) The expert's qualifications must establish that he or she has "the education, training, experience, or knowledge necessary to testify to the standards to be upheld in the practice" of the profession on which he or she is opining. (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 947.)

SIMPLE AND GROSS NEGLIGENCE

18. While a lack of ordinary care defines negligent conduct, gross negligence is defined by an error or omission that is egregious and flagrant. "Gross negligence

has been said to mean the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Van Meter v. Bent Construction Co.* (1946) 46 Cal.2d 588, 594; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

19. The concept of "gross negligence" was explained in the context of a disciplinary proceeding against a doctor in *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184. In that case, the doctor was accused if gross negligence with respect to his post-operative care of a patient, "by failing to diagnose, monitor and take sufficient steps to remedy a fluid and salt imbalance in the patient." (*Id.* at p. 189.) The administrative judge's proposed decision found that the doctor was negligent but concluded he did not engage in gross negligence. The board declined to adopt the proposed decision and instead decided that Dr. Gore had committed gross negligence. (*Id.* at pp. 189-190.) The appellate court noted that although an administrative law judge's decision may be entitled to great weight regarding his assessment of the credibility of witnesses, the board properly rejected the proposed decision because it "was based upon a mistaken belief of the administrative law judge that, under the circumstances of this case, 'gross' negligence would have required petitioner's conduct to be a cause of the patient's death." (*Id.* at p. 190.) After noting that Business and Professions Code section 2234 does not define "gross negligence," the appellate court reviewed the definitions provided in other appellate decisions as follows (*Gore, supra*, 110 Cal.App.3d pp. 196-198):

> In *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 123 Cal.Rptr. 563, the court was called upon to determine the meaning of the words "grossly negligent" in section 2960 as applicable to the conduct of a psychologist whose license had been revoked. After holding

that substantial evidence supported the trial court's findings, the court said (49 Cal.App.3d p. 941, 123 Cal.Rptr. p. 569): "Section 2960, subdivision (i), provides that a psychologist's license may be revoked if he is 'grossly negligent in the practice of his profession.' The California Supreme Court in *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594, 297 P.2d 644, defined 'gross negligence' as 'the want of even scant care or an extreme departure from the ordinary standard of conduct.' Dr. Mervin Freedman, whose qualifications were not challenged by appellant, testified that conduct such as that described in findings 3 and 5 constituted an 'extreme departure from the standard of practice of psychology.'"

As shown above, two of the medical expert witnesses in the instant case, Drs. Gerber and Silverman, testified that Dr. Gore's treatment of his patient was "an extreme departure" from standard medical practice. They were not asked and did not testify as to whether or not that treatment denied the patient "even scant care." Petitioner contends that failure to cover that aspect of the *Van Meter* definition leaves the evidence insufficient to support the findings of gross negligence. We disagree.

The language used by the *Van Meter* court is in the disjunctive, indicating that gross negligence could consist of either want of even scant care or extreme departure from

the ordinary standard of conduct, but not necessarily both. In *Cooper, supra*, the court's statement that gross negligence had been defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct" is immediately followed by the statement that a medical witness testified that the accused's conduct "constituted an extreme departure from the standard of practice of psychology," without mentioning whether or not it amounted to want of scant care. The implication is that proof of either, but not necessarily both elements, is sufficient.

This conclusion is confirmed by the authorities cited in *Van Meter, supra*, at page 595, 297 P.2d 644, in support of that court's definition of gross negligence. In *Kastel v. Stieber* (1932) 215 Cal. 37, 47-51, 8 P.2d 474, the court rejected the notion that gross negligence, as that term was used in our automobile guest statute, in effect in October 1929 (Cal.Veh. Act, § 1413/4), meant some degree of wantonness or willfulness. Indicating its adherence to definition of gross negligence as "a want of slight diligence" (215 Cal. pp. 46-47, 8 P.2d 474, 480) the court concluded that, "It must always be borne in mind that a state of facts relating to an automobile accident out on the open highway cannot be controlling as to the conclusions to be reached upon a corresponding state of facts occurring within city limits. The former might only reasonably be held negligence, while in

the latter, owing to the difference in the hazardousness of the situation, gross negligence would only be the right conclusion."

Prosser on Torts (1941), p. 260, also cited by the *Van Meter* court for its definition of gross negligence, reads as follows:

"Gross Negligence. This is very great negligence, or the want of even scant care. It has been described as a failure to exercise even that care which a careless person would use. Many courts, dissatisfied with a term so devoid of all real content, have interpreted it as requiring wilful misconduct, or recklessness, or such utter lack of all care as will be evidence of either-sometimes on the ground that this must have been the purpose of the legislature. But most courts have considered that 'gross negligence' falls short of a reckless disregard of consequences, and differs from ordinary negligence only in degree, and not in kind. So far as it has any accepted meaning, it is merely an extreme departure from the ordinary standard of care." (Emphasis added.)

Read in light of the authorities thus cited by the *Van Meter* court, the definition of gross negligence in *Van Meter* and *Cooper* means a want of even slight care, but not necessarily involving wanton or wilful misconduct; in other words, an extreme departure from the ordinary standard of care.

> Negligence and gross negligence are relative terms. "The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater, the actor is required to exercise caution commensurate with it." (Prosser, Law of Torts (4th ed. 1971), at p. 180.)
>
> In the instant case, Mrs. D'Abusco, having a history of impaired health and following major surgery, was wholly dependent on Dr. Gore for adequate post-operative care. Substantial evidence shows that he failed to exercise the standard of care in diagnosis, monitoring and treatment that is basically and routinely taught to students in medical school. Thus, management of his patient was an extreme departure from the standard of medical care, which we hold to be the equivalent of "want of even scant care" under the circumstances of this case.

REPEATED NEGLIGENT ACTS

20. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

INCOMPETENCE

21. "Incompetence" was defined in *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054, in which Dr. Kearl was disciplined for the

manner in which he administered anesthesiology on two patients. In that case, the Medical Board found that he engaged in gross negligence with respect to one patient and was incompetent in his choice of the anesthetic to use on the other patient. The appellate court explained the meaning of "incompetence" as follows (*Id.* at pp. 1054-1055):

> The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837, 149 Cal.Rptr. 787.) Incompetency is distinguishable from negligence, in that one "may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*, at p. 838, 149 Cal.Rptr. 787.) Thus, "'a single act of negligence . . . may be attributable to remissness in discharging known duties, rather than . . . incompetence respecting the proper performance.'" (*Ibid.*, quoting from *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62, 116 P. 400.) The *Pollack* court concludes: "While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a general lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute, we reject the notion that a single, honest failing in performing those duties-without more-constitutes the functional equivalent of incompetency justifying statutory sanctions." (85 Cal.App.3d at p. 839, 149 Cal.Rptr. 787, emphasis original.)

In the *Kearl* case, the appellate court concluded that the evidence supported the Medical Board's decision that Dr. Kearl was incompetent in his treatment of one patient based on expert testimony that he engaged in flawed reasoning when he chose an anesthetic which lead to a negligent act. (*Kearl, supra*, 189 Cal.App.3d at pp. 1055-1056.)

EVALUATION OF EXPERT OPINION TESTIMONY

22. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) "Like a house built on sand, the expert's opinion is no better than the facts on which it is based. . . . [W]here the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony." (*Ibid.*)

23. An expert witness "does not possess a carte blanche to express any opinion within the area of expertise. [Citation.]" *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.) "Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.]" (*Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36.)

24. Relying on some but not all of an expert's opinions may be entirely appropriate. "It is well settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may

also '"reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material.'" (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 777.) Furthermore, the fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

Evaluation of the Existence of Cause to Discipline Dr. Kingsbury

25. There was no dispute that while he was treating the patient, Dr. Kingsbury was well aware that the patient suffered from liver disease and had a history of substance abuse. Dr. Kingsbury prescribed Vicodin, which contains both hydrocodone, an addictive opioid pain medication, and acetaminophen, which Dr. Kingsbury was well aware should be limited for all patients and even more limited for patients with liver disease. The medical records indicated Dr. Kingsbury prescribed Vicodin for cough and for unidentified pain, which Dr. Kingsbury later indicated in the medical records was located in the patient's low back.

26. On November 21, 2011, Dr. Kingsbury learned from the patient that he believed he was addicted to Vicodin, and the pharmacist reported to Dr. Kingsbury that for several months the patient had been obtaining monthly supplies of Vicodin in two to three-week intervals and was at "toxic" levels. In the face of these red flags, Dr. Kingsbury continued to prescribe Vicodin to the patient even though the patient failed to heed Dr. Kingsbury's instructions to taper off the medication and the patient was taking more acetaminophen than was safe for a patient with liver disease.

27. Dr. Kingsbury also prescribed Ambien and Xanax, although not both during the same timeframes. Ambien was prescribed for months before it was ever noted in the medical records, and even then, the medical indication noted, for insomnia, was contradicted by other notes in the records that stated the patient was sleeping well. When Dr. Kingsbury stopped prescribing Ambien, and started prescribing Xanax, the indications varied from anxiety, to insomnia, to muscle spasm. Again, the indication for insomnia was contradicted by other notes in the medical records that the patient was sleeping well. Dr. Kingsbury was aware that both Ambien and Xanax can be habit forming and that benzodiazepines, like Xanax, in combination with opioids, such as the hydrocodone in Vicodin, can lead to respiratory suppression if the medications are misused. But the medical records did not indicate that Dr. Kingsbury ever discussed the dangers of taking Vicodin together with Xanax, a benzodiazepine, or Ambien, a benzodiazepine analog, even though Dr. Kingsbury was aware before he began prescribing Ambien or Xanax that the patient had been taking more Vicodin than Dr. Kingsbury intended.

28. After the patient reported to Dr. Kingsbury in June 2012 that he had been able to stop using Vicodin, which had resulted in severe withdrawal symptoms, Dr. Kingsbury again prescribed Vicodin to the patient in September 2012 based on a telephone message from the patient that he was suffering from back pain. Dr. Kingsbury did not examine the patient or note any type of assessment of the patient's claimed pain before reinitiating the Vicodin prescriptions. Then Dr. Kingsbury authorized multiple refills of Vicodin, even though Dr. Kingsbury was concerned the patient was using more than Dr. Kingsbury intended.

29. Dr. Kingsbury repeatedly authorized early refills of prescriptions when the patient claimed he needed them because he was going on vacation, lost his

medication, vomited on his medications, and that he needed the Vicodin for low back pain resulting from a club foot and later from a Go Kart accident.

30. Although Dr. Kingsbury was aware the patient was using the medication for non-medically indicated reasons and he counseled the patient to taper his use of Vicodin, Dr. Kingsbury continued to prescribe an excessive amount of the medication, including prescribing 240 Vicodin tablets at the last appointment, when the patient had told him he had suicidal ideations and a follow up appointment was set in two weeks. Even Dr. Kingsbury testified that prescribing that amount of Vicodin at that appointment was "ridiculous."

31. Dr. Kingsbury did not dispute that his medical records were not accurate or complete, and even he could not figure out why he did what he did from a review his own records.

32. As was explained by Dr. Franklin, Dr. Kingsbury engaged in multiple gross departures from the standard of the standard of care and some simple departures from the standard of care; prescribed excessive amounts of the medications Vicodin, Ambien, and Xanax to a patient he knew suffered from substance abuse disorder, opioid dependence, and liver disease; failed to maintain accurate and complete medical records of his treatment of this patient; demonstrated, particularly with respect to his repeated prescriptions of Vicodin to this patient and failure to control the patient's access to the medication after he was well aware the patient was misusing medication, a lack of knowledge (in other words incompetence) in his care and treatment of this patient; and prescribed dangerous drugs without a proper examination and appropriate medical indication.

33. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), because Dr. Kingsbury committed gross negligence in his treatment and care of the patient.

34. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), because Dr. Kingsbury committed repeated negligent acts in his treatment and care of the patient.

35. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227, 2234, and 725 because Dr. Kingsbury committed repeated acts of clearly excessive prescribing of drugs to the patient.

36. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227, 2234, 2266 because Dr. Kingsbury failed to maintain adequate and accurate records of his treatment and care of the patient.

37. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), because Dr. Kingsbury demonstrated a lack of knowledge (incompetence) in his treatment and care of the patient.

38. Cause therefore exists to discipline Dr. Kingsbury's physician's and surgeon's certificate, pursuant to Business and Professions Code sections 2242, subdivision (a), because Dr. Kingsbury prescribed dangerous drugs without an appropriate prior examination and medical indication.

Considerations Regarding Appropriate Level of Discipline

39. California Code of Regulations, title 16, section 1361, subdivision (a), provides:

> (a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

40. The Disciplinary Guidelines "set forth the discipline the Board finds appropriate and necessary for the identified violations." Disciplinary recommendations set forth in the Disciplinary Guidelines are meant to "promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection." The Disciplinary Guidelines also state:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board

- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

41. The Disciplinary Guidelines recommend revocation as the maximum discipline for all the categories of misconduct found in this matter. The Disciplinary Guidelines recommend the following minimum levels of discipline:

- For gross negligence, repeated negligent acts, and/or incompetence under Business and Professions Code section 2234, subdivisions (b), (c), and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices.

- For excessive prescribing under Business and Professions Code section 725 or Prescribing without an appropriate prior examination under Business and Professions Code section 2242, revocation, stayed, and five years' probation, with conditions including a 60-day suspension, a Drug Enforcement Administration (DEA) controlled substances restriction, maintenance of controlled substance records, education course,

prescribing practices course, medical record keeping course, professionalism course, clinical competence course, and monitoring.

Evaluation

42. Dr. Kingsbury has practiced medicine for over 20 years without any prior discipline. The conduct at issue was very serious and involved numerous failures to meet the standard of care related to a single patient and medical records that did not provide accurate or complete information about the patient's care and treatment and which records were at times contradictory.

43. Dr. Kingsbury has taken what happened with this patient very seriously, and he credibly acknowledged his responsibility and expressed his remorse and regret. Shortly after learning that the patient had taken his own life by overdosing on controlled substances, Dr. Kingsbury took proactive steps to assure that such a tragic incident does not happen again. Dr. Kingsbury prepared and began using a contract and informational pamphlet with patients to whom he prescribes opioid pain medications, he began seeing patients in person every other prescription, he began requiring drug testing once or twice a year depending on the circumstances, and he also more recently began regularly checking the CURES database on a regular basis and started using an electronic program to more closely monitor the medications dispensed to his patients in "real time."

44. After the accusation was filed, Dr. Kingsbury completed medical record keeping and prescribing courses.

45. Dr. Kingsbury called two doctors who have known him professionally for many years as character witnesses and presented letters they wrote on his behalf. Those two doctors gave glowing reports of Dr. Kingsbury's skill as a physician.

46. Complainant requested that Dr. Kingsbury's certificate be placed on probations for a term and on conditions consistent with the Disciplinary Guidelines. Dr. Kingsbury requested that the discipline imposed be a letter of reprimand and asked that he not be placed on probation. Dr. Kingsbury argued that a departure from the recommendations in the Disciplinary Guidelines was warranted because the conduct that led to this proceeding occurred over six years ago; the medical community standards and attitudes regarding the treatment of pain with opioid medication have since changed dramatically; Dr. Kingsbury regretted and took responsibility for his mistakes; and he has made changes in his prescribing and record keeping practices.

47. Despite Dr. Kingsbury's efforts to educate and rehabilitate himself and the passage of time since the incidents that resulted in this proceeding, due to his extensive, serious, and repeated departures from the standard of care during the course of his treatment of this patient, this is not a case where a letter of reprimand, which would be a significant departure from the board's Disciplinary Guidelines, is appropriate. Dr. Kingsbury allowed a person he knew suffered from substance abuse issues to manipulate him repeatedly, he overprescribed acetaminophen to a patient with liver disease, and even when he recognized that the patient needed to be weaned off the medication, he failed to take proactive steps to make sure that happened. Dr. Kingsbury also completely failed to adequately or accurately document his care of the patient.

48. Under the circumstances, it is important that Dr. Kingsbury be monitored and participate in additional education and training, including a clinical competence assessment program. Such assessment and educational components are ordered in large part due to concerns that Dr. Kingsbury, who is a solo practitioner and noted that

he "had a soft spot for lost souls," needs to gain the skills necessary to avoid anything similar happening in the future.

At the same time, some departures from the recommended length of probation and some of the recommended conditions are warranted here after taking the following into consideration: the amount of time that has lapsed since the treatment of the patient in question; this case involved a single patient; Dr. Kingsbury had no prior disciplinary action against his certificate; Dr. Kingsbury credibly testified about his current understanding of his errors; and Dr. Kingsbury has made important changes to how he treats patients with pain medication. Therefore, the length of probation shall be 35 months instead of five years, he shall be allowed to continue to operate as a solo practitioner while on probation, an actual suspension shall not be ordered, and no restrictions on his DEA registration or his practice shall also be required.

ORDER

Certificate No. A 64822 issued to respondent A. Grant Kingsbury, M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for 35 months 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 (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.

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 (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 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. 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 3 and no more than 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.

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.

6. 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.

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. 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.

7. 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.

8. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. General Probation Requirements

COMPLIANCE WITH PROBATION UNIT

Respondent shall comply with the Board's probation unit.

ADDRESS CHANGES

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

PLACE OF PRACTICE

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

LICENSE RENEWAL

Respondent shall maintain a current 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.

12. 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.

13. Non-practice While on Probation

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

shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

14. 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.

15. 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.

16. 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.

17. 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: August 21, 2019

DocuSigned by:
Theresa Brehl
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THERESA M. BREHL

Administrative Law Judge

Office of Administrative Hearings