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

In the Matter of the Accusation Against: Corinne Vivian Basch Physician's and Surgeons License No. A 51185 Respondent.	Case Nos. 800-2017-036460 800-2019-056378

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 15, 2021.

IT IS SO ORDERED: December 17, 2020.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: **CORINNE VIVIAN BASCH, M.D.** 4641 Valley East Blvd Ste 2 Arcata, CA 95521 **Physician's and Surgeon's Certificate No. A 51185** Respondent.	Case No. 800-2017-036460 OAH No. 2020030661 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) brought this action solely in her official capacity as the Interim Executive Director of the Medical Board of California (Board) and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

2. Respondent Corinne Vivian Basch, M.D., is represented in this proceeding by attorney Amelia F. Burroughs, Esq., whose address is: 730 Fifth Street, Eureka, CA 95501.

3. On or about September 15, 1992, the Board issued Physician's and Surgeon's Certificate No. A 51185 to Corinne Vivian Basch, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-036460, and will expire on September 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036460 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 8, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-036460 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-036460. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-036460, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent gives up her right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

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

CONTINGENCY

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

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

14. If the Board adopts this stipulation as its Decision and Order, the Board agrees to take no further action in Case No. 800-2019-056378, which is pending investigation.

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

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 51185 issued to Respondent Corinne Vivian Basch, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months from the effective date of the Decision on 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 of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

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

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 30 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, including the prescribing of controlled substances, 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 50 hours of CME of which 30 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 no 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 no later than 15 calendar days after successfully completing the course, or no 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 no 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 no later than 15 calendar days after successfully completing the course, or no later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program no later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program no later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the program or no later than 15 calendar days after the effective date of the Decision, whichever is later.

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. A local monitor is permitted subject to the Board's approval. 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, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (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.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent may supervise physician assistants and advanced practice nurses, but is required to obtain prior approval from the Board for each physician assistant or advanced practice nurse under her supervision.

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 no 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(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, or is debilitated.

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) no 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 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.

ACCEPTANCE

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

DATED: 8/28/2020

CORINNE VIVIAN BASCH, M.D.
Respondent

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

DATED: 08.28.2020

AMELIA F. BURROUGHS, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: Aug. 28, 2020

Respectfully submitted,

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

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

SF2018201567

Exhibit A

Accusation No. 800-2017-036460

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO May 8 20 19
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: **Corinne Vivian Basch, M.D.** 4641 Valley East Blvd Ste 2 Arcata, CA 95521 **Physician's and Surgeon's Certificate No. A 51185,** Respondent.	Case No. 800-2017-036460 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about September 15, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number A 51185 to Corinne Vivian Basch, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2020, unless renewed.

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JURISDICTION

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

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

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

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

". . . ."

"(b) Gross negligence.

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

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

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

". . . ."

6. Section 2266 of the Code 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."

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7. Section 725, subdivision (a), of the Code states, in pertinent part, that "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

FACTS

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

PATIENT P-1[1]

9. Patient P-1 was 61 years old when Respondent assumed her care in February 2014. Respondent continued treating P-1 until at least 2018 during which time she saw P-1 regularly. P-1 had a number of medical issues including osteoarthritis, sleep apnea, and obesity and used a motorized scooter to get around. When Respondent began treating P-1, she was on a combination of large doses of opioids and benzodiazepines. Respondent documented a regimen including methadone,[2] oxycodone[3] 15 mg and 30 mg, and diazepam[4] although it appears that she was also receiving a second benzodiazepine, lorazepam,[5] at that time. Her treatment plan was to refer P-1 to a specialist for her osteoarthritis, order a sleep study and lab testing, discuss diet and exercise, monitor P-1's elevated blood pressure, and refer for counseling for her anxiety issues. She

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[1] The patients are designated in this document as Patients P-1 through P-5 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Methadone is an opioid medication. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs.

[3] Oxycodone is a short-acting opioid whose principal therapeutic action is analgesia. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code. It is a more potent pain reliever than morphine or hydrocodone.

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

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

recommended that P-1 take her methadone four times per day instead of three, stop taking diazepam, switch to a long-acting opioid, and try Cymbalta.[6] Additionally, Respondent wrote in the progress note that P-1 was on a "[d]angerous regimen right now with high doses of opioids, excessive short-acting medications, benzodiazepines in combination. Discussed my concerns about this with patient, who is resistant to change and speaks with appreciation of last provider, who allowed her to adjust medications herself, also appreciates the relief she gets when she takes up to 60 mg oxycodone and can feel it coming on as she is sitting in her chair (!)." She repeated this exact language in her chart notes throughout the years she treated P-1.

10. Respondent continued to make referrals for P-1 to physical therapists, orthopedists, sleep specialists, counselors, and other specialists throughout the period she treated her. On December 29, 2014, she made a referral to a pain specialist to discuss P-1's current medication use but did not follow up on it and did not make a subsequent such referral even though three and a half years later, P-1 was still on high doses of opioids and benzodiazepines.

11. On her second visit, February 17, 2014, Respondent had P-1 sign a pain contract entitled "Informed Consent Agreement for Treatment of Intractable Pain with Narcotics." This document includes, among other things, a list of the medication prescribed for P-1, P-1's functional goals, the risks of narcotic use, and a list of guidelines to which P-1 agreed to adhere including keeping all appointments, not changing dosages or timing of medication without doctor approval, trying alternative modalities, submitting to urine testing, and understanding that she would be unable to obtain early refills or replacement of lost or stolen medication. The pain contract reflects that P-1 agreed to take the following medications as prescribed: methadone 10 mg, 2 tablets three times a day (60 mg/day); oxycodone 15 mg, 1 tablet as needed four times a day (60 mg/day); oxycodone 30 mg, 1-2 tablets every four hours as needed, up to a maximum of

[6] Cymbalta, a trade name for duloxetine, is a selective serotonin and norepinephrine reuptake inhibitor. It is used to treat depression and anxiety. Duloxetine is a dangerous drug as defined in section 4022.

6 per day (maximum of 180 mg/day), for a total MME[7] of 960.[8] In addition, the contract included lorazepam, 1 mg, 1-2 per day. In chart notes identical to those from P-1's first visit, Respondent noted that she had discussed stopping P-1's Valium, replacing some of the short acting oxycodone with long-acting, and having her take the methadone four times a day instead of three.

12. Respondent noted on February 27, 2014 that P-1 had stopped taking Valium and that she intended to taper the lorazepam in the future. Lorazepam first shows up on the list of P-1's current medications in April 2014. The dosage listed is 1 mg two times a day. In December 2014, the dosage of lorazepam is listed as 1 mg three times a day with a prescription for enough tablets to take 2.5 mg a day.

13. P-1 had an ECG on March 14, 2014 which showed a prolonged QT interval[9] and nonspecific T wave abnormality. Respondent noted that the prolonged QT was likely related to medications and that she was concerned for arrhythmias at P-1's current dose of methadone. Respondent did not monitor P-1 with repeat ECGs although she continued prescribing high doses of methadone throughout her treatment of P-1, even increasing the dose at various times. For example, she raised P-1's methadone prescription from 60 mg a day to 80 mg a day in April 2014, down to 70 mg a day at the end of April, back up to 80 mg a day in May, and back to 70 mg in June. On June 19, 2014, P-1 admitted to Respondent that she had increased her methadone dose on her own by 10 mg per day.

14. On April 30, 2014, Respondent wrote in her chart notes, "Already in case here she has overused methadone, expressed surprise she was filling diazepam and lorazepam both

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[7] MME stands for morphine milligram equivalency. It is also referred to as MED or morphine equivalent dose. It is used convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 60 mg of oxycodone is equivalent to 90 MME. Calculating the MME for methadone is more complex. The Centers for Disease Control and Prevention and many other entities and organizations use a conversion factor that increases at higher doses. One to 20 mg per day is treated as 4 times as potent as morphine; 21 to 40, 8 times as potent; 41 to 60, 10 times as potent; and 61 to 80, 12 times as potent.

[8] Respondent calculated the total MME as 660, apparently incorrectly using a conversion factor of 5 for the methadone.

[9] Long QT syndrome is a heart rhythm condition that can potentially cause fast, chaotic heartbeats, which could trigger fainting spells or seizure and is characterized by a prolonged QT interval. Certain medications such as methadone might cause acquired long QT syndrome and methadone has a black box warning to monitor patients with QT prolongation risk factors for ECG changes when increasing doses.

monthly, etc. Now planning on taper of opioids - will monitor closely since she is not managing meds well." She repeated this exact language in most of her subsequent chart notes for P-1. In fact, throughout Respondent's progress notes for P-1, she cut and pasted much of the information making it very difficult, if not impossible, to know what actions were being taken when.

15. P-1 regularly breached her pain medication contract without apparent consequences despite Respondent's regularly including in her chart notes the statement, "plan enforcement with no exceptions." For example, on March 10, 2014, at an urgent office visit, P-1 admitted taking 7 methadone tablets per day instead of the 6 agreed upon; on August 28, 2014, P-1 reported that she had decided on her own to increase her pain medications in different combinations for a three day period to see if she could get significant relief; on September 11, 2014, P-1 reported that she had had to go to the ER for a dose of lorazepam because she had overused it and run out early and she had been using an additional 45-60 mg of oxycodone over the amount prescribed because of having to drive to work and walk up stairs; on October 16, 2014, Respondent wrote that P-1 had consistently been filling her prescriptions early; on November 11, 2014, Respondent noted that P-1 had run out of medications again despite their agreement at the last refill; on December 9, 2014, P-1 e-mailed Respondent asking for an early refill of methadone and Respondent agreed to refill the prescription but said that they were having an ongoing problem with respect for limits to which P-1 replied that she was sick of being called on the carpet for her use of narcotic medication; on February 18, 2015, Respondent gave P-1 an early refill of oxycodone in response to her request claiming increased pain because of an infection in her arm; on April 7, 2015, P-1 reported that she had overused lorazepam because of a urinary tract infection and her daughter's surgery; on May 19, 2015, P-1 asked for and received additional lorazepam and additional pain medications for a trip to a friend's house and Respondent noted that when she tapered P-1's pain medications, P-1 continually filled the prescriptions early with various excuses, initially to help with work, but now that she was not working, blaming it on the weather; on November 10, 2015, Respondent allowed an early refill of lorazepam because of an assault on P-1's daughter; on December 1, 2015, Respondent gave P-1 an early refill of her pain medications because she said she was traveling to see her daughter who was seriously injured in an assault; on January 14,

2016, Respondent wrote, in response to a request for an early refill, that P-1 continued to use medications as she felt she needed and continued to minimize Respondent's concerns, but she nonetheless gave P-1 the refill with the plea, "PLEASE make it 28 days next month"; on May 23, 2016, Respondent documented a new medication contract with the admonition, "Plan enforcement with no exceptions"; on June 26, 2016, Respondent increased P-1's oxycodone 30 to a maximum of 7 tablets a day; on August 8, 2016, P-1 e-mailed Respondent saying she was using 3 tablets of lorazepam a day because she had such a stressful life and Respondent increased her prescription; on August 14, 2016, P-1 asked for and received an early refill to go camping; on September 2, 2016, P-1 requested an early refill of lorazepam; on October 4, 2016, Respondent responded to P-1's e-mail asking for a change in her prescriptions saying that P-1 was asking her to violate the medication contract again, that she would make the change requested, but that she "would ask [P-1] to respect the contract . . . in the future" and that she felt that P-1 did whatever she wanted "to do with the medications, ignoring [Respondent's] requests and directions"; on December 15, 2016, P-1 asked for an early refill of lorazepam again with another sad story of why she needed it and, while not completely clear from Respondent's medical records, it appears that Respondent agreed to it after initially refusing; on August 6, 2017, P-1 sought an early refill of lorazepam because, she said, she had spilled the ones she had in the sink and had also used a few extra because of all that was going on in her life that month; and in January 2018, P-1 said she was out of medications early because someone had been diverting them, possibly her new in-home care person, and Respondent gave her an early refill.

16. Over the period that Respondent treated P-1, she raised her MME from 960 to as high as 1275, and ultimately managed to reduce the initial MME by only approximately one-third to 628. Respondent documented prescribing 2 mg of lorazepam a day for P-1 initially, increasing it to 3 mg daily, back to 2 mg, and, finally, in mid-2018, down to 1.25 mg daily.

17. As noted above, Respondent's initial pain medication contract with P-1, dated February 17, 2014, provided for up to 180 mg oxycodone 30, 60 mg oxycodone 15, 60 mg methadone, and 2 mg lorazepam per day for a total MME of 960. Respondent documented her intention to decrease P-1's reliance on opioid medications and benzodiazepines throughout the

time she treated P-1. She advised P-1 on March 20, 2014 that the maximum recommended MME was 120 and reminded her on several other occasions that her total MME was many times that amount including on July 18, 2018 when she told her the maximum was 90.

18. In May 2014, Respondent increased P-1's methadone to 80 mg a day and increased the amount of oxycodone 30 available to P-1 per day from 3 tablets to 4 for a total MME of 1275. Respondent documented a new contract with P-1 on December 29, 2014 which provided for 60 mg of methadone per day and a maximum of 180 mg of oxycodone 30 per day and 90 mg of oxycodone 15 per day for a total MME of 1005. In addition, the contract provided for 3 mg of lorazepam per day. On May 23, 2016, Respondent documented another new medication contract which provided for 50 mg of methadone a day, 180 mg of oxycodone 30 a day, and 75 mg of oxycodone 15 a day for a total MME of 882.5. On December 21, 2016, Respondent documented 45 mg of methadone a day (although she prescribed enough for 50 mg daily), 75 mg of oxycodone 15 a day (although she prescribed enough for 83 mg daily), and 180 mg of oxycodone 30 a day. The total MME of the prescribed opioids was 894.5. On July 13, 2017, Respondent's opioid prescriptions for P-1 amounted to an MME of 714.5 with methadone down to 40 mg a day. She prescribed 2 mg of lorazepam a day with an admonition to taper. On February 7, 2018, Respondent was prescribing a total daily MME of 628 plus 2 mg of lorazepam. On July 12, 2018, the last day for which records are available, she was prescribing 612.5 MME per day and an average of 1.25 mg a day of lorazepam.

19. On July 12, 2018, P-1 reported overusing all of her opioids and the lorazepam and again provided multiple excuses for her overuse. Respondent did not refill her prescriptions early this time but instead prescribed buprenorphine[10] for opioid withdrawal until she could get her opioids refilled on the regular schedule and prescribed clonazepam[11] 2 mg a day for three days to prevent benzodiazepine withdrawal.

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[10] Buprenorphine is an opioid medication. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule III controlled substance and narcotic as defined in section 11056 of the Health and Safety Code. Buprenorphine is used as a pain reliever and as part of drug addiction detoxification and maintenance programs.

[11] Clonazepam is a benzodiazepine used to treat certain seizure disorders and panic disorder. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in section 11057 of the Health and Safety Code.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

20. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), and/or section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or repeatedly prescribed excessively and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent prescribed excessive amounts of opioid medications and benzodiazepines for Patient P-1.

B. Respondent failed to lower Patient P-1's pain medications to a safe level in a timely manner.

C. Respondent failed to refer Patient P-1 to a pain specialist despite failing to taper her off high doses of medications.

D. Respondent repeated paragraphs verbatim from visit to visit in her chart notes for Patient P-1 leading to confusion as to when a given event happened.

E. Respondent failed to adhere to the medication contract she had entered into with Patient P-1.

F. Respondent failed to adequately monitor Patient P-1's QT interval despite the high dose of methadone she was prescribing for her.

PATIENT P-2

21. Patient P-2 was 46 years old when Respondent assumed her care in July 2015. Respondent continued treating P-2 until at least June 2018 during which time she saw P-2 regularly. P-2 had a number of medical issues including chronic pain following multiple bilateral knee surgeries and right knee replacement, neuropathy, and chronic constipation. It is not clear from the medical records what medications P-2 was on when Respondent began treating her. The chart notes for her August 15, 2015 visit appear to reflect that P-2 had been hospitalized in June

2015 for constipation related to opioids and that she stopped taking fentanyl and hydrocodone and replaced them with Butrans[12] and tramadol.[13] The current medication list in the chart note, however, lists neither of these medications. Also, while Respondent wrote in these chart notes that P-2 was constipated after starting suboxone[14] and that "[t]he suboxone is not helping, even after the dose increase and enough med to provoke sedation," there is no documentation in this or the previous chart notes that P-2 was taking suboxone. It is possible that she was referring to the Butrans. On this visit Respondent prescribed Butrans 20 mcg/hour patch, one patch per week. There is no documentation that Respondent discussed the risks and benefits of this opioid medication. While Respondent's chart notes for August 15, 2015 do not indicate that P-2 was taking alprazolam,[15] progress notes from the Stanford General Neurology Clinic for a visit eleven days earlier reflect that at that time P-2 was taking alprazolam 0.5 mg three times a day. Respondent did not document a discussion of the risks of combining opioids with benzodiazepines. On November 21, 2015, Respondent documented for the first time that she had prescribed tramadol (50 mg twice a day) for P-2, again without noting a discussion of the risks and benefits.

22. Respondent was treating P-2 with two opioid medications, tramadol and buprenorphine, for her chronic pain along with a benzodiazepine, alprazolam, but failed to document clear goals and objectives for the continued use of the medications in the treatment of

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[12] Butrans transdermal system is a patch containing buprenorphine which is used for the management of moderate to severe chronic pain in patients requiring continuous, around the clock opioid analgesic for an extended period of time. It is a dangerous drug as defined in section 4022 of the Code and a Schedule III controlled substance as defined in Health and Safety Code section 11056.

[13] Tramadol hydrochloride is a centrally acting opioid analgesic indicated for the management of moderate to moderately severe pain. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule II controlled substance and narcotic as defined in section 11057 of the Health and Safety Code.

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

[15] Alprazolam, also known by the trade name Xanax, is a benzodiazepine used for the management of anxiety disorders for the short-term relief of symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057. Alprazolam is a central nervous system (CNS) depressant.

P-2's chronic pain and failed to have P-2 sign a pain contract. On January 16, 2016, Respondent observed, without describing a plan or giving an explanation, that P-2 "[h]as been weaning off opioids." On this same visit, Respondent noted that P-2 had doubled her tramadol usage.

23. Also on January 16, 2016, Respondent added trazodone,[16] another sedating medication, to P-2's mix of sedating medications, tramadol, buprenorphine, alprazolam, amitriptyline,[17] and Lyrica.[18]

24. Respondent continued noting at subsequent visits through at least January 7, 2017 that P-2 was weaning off opioids. This includes her notes for P-2's visit on July 1, 2016, when Respondent documented that P-2, on her own, had increased her tramadol intake from 2 tablets in the morning and at night to 3 tablets morning and night. Respondent responded by permitting P-2 to take up to 8 tablets a day, warning her that excessive tramadol can cause seizures. Throughout this time, Respondent did not document a plan for tapering the medications.

25. On November 19, 2016, Respondent noted both that P-2 occasionally needed to take a fifth tramadol pill and that she had been able to wean opioids to one tramadol pill per day max.

26. Throughout Respondent's chart notes for P-2, she cut and pasted much of the information making it very difficult, if not impossible, to know what actions were being taken when. For example, Respondent's notes for November 21, 2015, January 16, 2016, and February 2, 2016, include, verbatim, "Starting metformin now – side effects and precautions reviewed," and her notes from November 21, 2015 until April 1, 2017, when P-2 was diagnosed with Stage IIIB anorectal cancer, include, also verbatim, "Chronic constipation - symptomatic remedies suggested, improved with magnesium. Consider further gut work-up in near future." There are

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[16] Trazodone is used for the medical treatment of depression. In addition to depression, it may also be prescribed as a treatment for insomnia, anxiety, and panic attacks. It is a dangerous drug as defined in section 4022.

[17] Amitriptyline, also known by the trade name Elavil, belongs to a class of medications called tricyclic antidepressants. It is used to treat depression and works on the central nervous system (CNS) to increase levels of certain chemicals in the brain. It is a dangerous drug as defined in section 4022.

[18] Lyrica is the trade name for pregabalin, an antiepileptic medication. It is indicated for the management of neuropathic pain associated with diabetic neuropathy, postherpetic neuralgia, fibromyalgia, and adjunct therapy in adults with partial onset seizures. It is a dangerous drug as defined in section 4022 and a Schedule V controlled substance as defined in Health and Safety Code section 11058.

also many pages what appear to be internal messages that are incomprehensible and impossible to follow.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

27. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (c), and/or section 2266 of the Code in that Respondent committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to document functional goals and objectives for the treatment of Patient P-2's pain.

B. Respondent failed to adequately discuss the risks and benefits of the controlled substances prescribed to Patient P-2.

C. Respondent's medical records for Patient P-2 are often confusing, include paragraphs repeated verbatim from visit to visit, are not in chronological order, and include a number of pages that appear to be internal messages that are incomprehensible and impossible to follow.

D. Respondent failed to secure Patient P-2's agreement to a pain medication contract, failed to develop a clear plan that explained the reason for combining opioids and benzodiazepines and other sedating medications, and failed to document a plan for tapering the medications.

PATIENT P-3

28. Patient P-3 was 64 years old when Respondent assumed her care in mid-2014. Respondent treated P-3 until at least 2017 during which time she had frequent visits. P-3 had multiple medical issues including chronic pain from degenerative joint disease and osteoarthritis. Although it is difficult to tell from the medical records, it appears that when Respondent began treating P-3, she was taking the opioid medication hydromorphone[19] and two benzodiazepines,

[19] Hydromorphone, also known by the trade name Demerol, is an opioid analgesic. It is a a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic

temazepam[20] and clonazepam, daily along with additional CNS depressants butalbital/ASA/C[21] and nortriptyline.[22] Her MME was 160. Chart notes for P-3's first visit or visits are missing but in her June 4, 2014 chart note, Respondent wrote, "Last time reviewed further increase in opioids would be warranted only if function dramatically improved – discussed activities we would use to monitor this. Added fentanyl[23] and patient very happy with the increase, however did not see organic reduction in dilaudid as hoped for." She repeated this statement verbatim in her chart notes over the next several months. With the addition of the fentanyl patch, P-3's MME was 340.

29. There is an unsigned Informed Consent Agreement for Treatment of Intractable Pain with Narcotics in P-3's medical record dated May 17, 2014 that confirms that as of that date P-3 was being prescribed the medications listed above including the fentanyl that Respondent added. The Agreement states that P-3's age is 67 when in fact she was 64 on that date.

30. On June 4, 2014, Respondent's chart notes reflect that P-3 had missed her last 2 appointments and that the office staff had stated that she had been exhibiting cognitive impairment in their recent interactions with her. Respondent advised P-3 that she was concerned about her memory problems, that she had advised last time that her clonazepam usage should be no more than 2 per day, and that she felt strongly about it. Respondent documented that P-3

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as defined in section 11055 of the Health and Safety Code. Hydromorphone is four times as potent as morphine and can produce drug dependence. It has a central nervous system depressant effect.

[20] Temazepam, also known by the trade name Restoril, is a benzodiazepine and a CNS depressant. It is used for the short-term treatment of insomnia. Temazepam is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined in Health and Safety Code section 11057.

[21] Butalbital is a barbiturate with intermediate duration. It is used in the treatment of pain, anxiety, and seizures and is often combined with aspirin (ASA), caffeine (C), or acetaminophen (APAP) for the treatment of pain and headaches. It is a CNS depressant. Butalbital is a dangerous drug as defined in section 4022 and is a Schedule III controlled substance and narcotic as defined in Health and Safety Code section 11056.

[22] Nortriptyline is a tricyclic antidepressant used in the treatment of depression, anxiety, and nerve pain, among other things. It may potentiate the action of CNS depressants. Nortriptyline is a barbiturate with intermediate duration. It is a dangerous drug as defined in section 4022.

[23] The fentanyl patch, also known by the trade name Duragesic, is a transdermal system containing fentanyl, an opioid analgesic used to treat severe pain. It is a central nervous system depressant. Fentanyl is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined in section 11055 of the Health and Safety Code.

shrugged her concern off and did not seem to take the recommendation seriously. Respondent continued to prescribe clonazepam with directions to take 4 times a day as needed.

31. On September 24, 2014, Respondent noted that P-3's insurance company had called and wanted to increase P-3's fentanyl from 75 mcg to 100 mcg and reduce her short-acting opioid, hydromorphone, from 40 mg to 24 mg. P-3 contended, as she did on other occasions, that she did not do well with timed release pain medications and resisted the change.

32. Although Respondent noted as early as September 24, 2014 that increasing opioids had not resulted in any lower pain for P-3 and that giving her stronger pain medications would not be a successful strategy, by 2017 she had increased P-3's total opioid load from an MME of 160 to an MME of 424.

33. Respondent's chart notes for January 19, 2017 and for April 27, 2017 both state, "Finally tapering, and tolerating fentanyl!" but, as described above, it does not appear that P-3 is tapering her opioid medications nor does it appear that P-3 is taking fentanyl on those dates. Her opioid medications were described as OxyContin,[24] dilaudid (hydromorphone), and oxycodone.[25]

34. The notes for January 19, 2017, April 27, 2017, and June 27, 2017, the last date for which records are available, set out a confusing history of Respondent's opioid prescribing for P-3. Parts of the history are identical in the three sets of notes. The history includes an indecipherable jumble of medications and MMEs, notes that a pain management specialist supported P-3's remaining on a previous dose level without identifying which dose level that was, and miscalculates the total MMEs.

35. Respondent continued prescribing two benzodiazepines, clonazepam and temazepam, throughout her treatment of P-3 despite the high levels of opioid medications she was taking and despite P-3's having reported drinking one to two alcoholic drinks a day and sometimes using

[24] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined in section 11055 of the Health and Safety Code. It is a more potent pain reliever than morphine or hydrocodone.

[25] Oxycodone is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined in section 11055 of the Health and Safety Code. It is a more potent pain reliever than morphine or hydrocodone.

alcohol for pain management. She also continued to prescribe butalbital throughout the time she was treating P-3.

36. Throughout Respondent's chart notes for P-3, she cut and pasted information making it very difficult, if not impossible, to know what actions were being taken when. There are also many pages that appear to be internal messages that are incomprehensible and impossible to follow.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

37. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), and/or section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or repeatedly prescribed excessively and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent prescribed excessive amounts of opioid medications, benzodiazepines, and other CNS depressants for Patient P-3 throughout the time she was treating her despite a lack of evidence that they were working.

B. Respondent failed to follow through on plans to taper Patient P-3's pain medications to a safe level in a timely manner.

C. Respondent's chart notes are not clear as to the timing of events.

PATIENT P-4

38. Patient P-4 was 52 years old when Respondent assumed his care in July 2014. Respondent continued treating P-4 until at least July 2018 during which time she saw P-4 on a regular basis. P-4 had a number of medical issues including cervical radiculopathy, spondylolisthesis, and chronic pain. When Respondent began treating P-4, he was on large doses of oxycodone—960 mg a day (MME 1440)—along with a daily 30 mg dose of temazepam, a benzodiazepine, for sleep.

39. Respondent's treatment plan included referring P-4 to a pain management specialist because of the high dose of opioid medications. P-4 saw the pain specialist on September 22, 2014 and the specialist recommended decreasing P-4's "overall" oxycodone dose by 10% a month until he was on a dose of no more than oxycodone 10 mg four times a day and OxyContin 80 mg three times a day, an MME of 420 daily. The specialist noted that because of the high doses of oxycodone P-4 was on, he might need inpatient rehabilitation to reach that level.

40. On P-4's next visit with Respondent, on October 3, 2014, she did begin to taper P-4's oxycodone but only reduced the short-acting oxycodone by 10%, from 360 mg a day to 324 mg a day, not the overall oxycodone dose. This resulted in a 3.75% reduction of the overall oxycodone dose instead of the 10% reduction recommended by the pain specialist. Respondent continued the taper over the next several months, continuing to reduce just the short-acting oxycodone. Four and a half months after starting the taper, the total opioid dose had been reduced by only 15.6% instead of the nearly 40% reduction that would have resulted from the pain specialist's recommendations. Already behind on the taper, Respondent reversed course on February 13, 2015 and increased P-4's short-acting oxycodone from 210 mg to 300 mg a day for a total daily dose of 900 mg of oxycodone, an MME of 1350. This is only 6% lower than when Respondent started to taper P-4's oxycodone dose four and a half months earlier.

41. Over a year after opining in July 2015 that there was a possibility that P-4's pain would improve if his opioid medications were tapered, Respondent was prescribing the same 900 mg of oxycodone and still holding off on tapering P-4's opioid medications pending any further surgery.

42. In March and April of 2016, P-4 advised Respondent that his pills were arriving late and sought additional oxycodone each month to cover the respective periods until his medications arrived. Respondent noted that P-4 had been getting a 30 day supply every 28 days and should have been budgeting his regular pills to have a buffer. Nonetheless, she gave him a prescription for 60 tablets of oxycodone in March, advising him that it should be more than enough for the day so he would have a stash for the next time as well, and a prescription for an additional 100 tablets in April.

43. In June 2016, Respondent resumed a very slow taper of P-4's opioid medications. By March 13, 2017, P-4 was down from an MME of 1350 to an MME of 1155. At that visit he complained of significantly worse pain and threatened to turn to the street for additional medications. Respondent stopped the taper and increased P-4's oxycodone by 30 mg a day, raising the MME to 1200.

44. On June 5, 2017, Respondent prescribed Narcan[26] "for safety."

45. Despite prescribing such high levels of opioids and despite noting in nearly every chart note that Restoril—the benzodiazepine temazepam—was risky in combination with opioid medications, Respondent continued prescribing Restoril 30 mg for P-4 for problems with sleep throughout the time she treated him. In fact, in August 2016, she added a three-month supply of an additional 15 mg dose of temazepam for a total of 45 mg of temazepam daily.

46. Although it appears that Respondent only prescribed the additional 15 mg dose of temazepam for the three-month period, it remains, along with Restoril 30 mg, in the current medication list of every subsequent chart note. In addition, all or nearly all of the current medication lists provide that P-4 was to take the OxyContin 40 mg every 6-8 hours "as needed" and the OxyContin 80 mg every 4 hours although the directions set out in the prescription section of the chart notes provided otherwise. The directions for the OxyContin 40 mg did not include "as needed" or prn and the directions for the OxyContin 80 mg were to take the medication three times a day, not every 4 hours.

47. On June 30, 2017, Respondent's chart notes state that P-4 was still not sleeping and that he wanted to try Ambien. Respondent noted that she discussed "precautions" and prescribed 10 mg Ambien for P-4 along with his regular 30 mg dose of temazepam. Respondent's chart notes state "[c]urrently dependent on restoril, but risky in combination with the other medications. Trial of remeron unsuccessful. Reviewed sleep hygiene, encourage magnesium, trying

[26] Narcan, a trade name for naloxone, is an opioid antagonist and is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids. Narcan is also indicated for diagnosis of suspected or known acute opioid overdosage.

ambien.[27]" This exact line recurs in the chart notes for every visit through July 2, 2018, the last date for which records are available. This verbatim repetition of information occurs throughout Respondent's chart notes.

48. Respondent's chart notes for August 29, 2017 state that P-4's surgery was scheduled for that week and that she was prescribing "[s]ome extra oxycodone 20's for postop pain." In fact, in addition to adding 6.7 tablets a day of oxycodone 20 mg, the prescriptions list also includes an additional 4 tablets a day of oxycodone 30 mg, from 8 tablets a day back up to 12 tablets a day. The total daily MME of opioids she prescribed for P-4 on this date is 1580, higher than when she began treating him.

49. P-4 finally had the long-awaited surgery on his neck the last day of August 2017.

50. On September 26, 2017, Respondent began another taper of P-4's opioid medications. She continued a slow taper of P-4's oxycodone and OxyContin over the following year, reducing P-4's total daily MME to 630 by July 2, 2018, the last day for which records are available. This is still significantly higher than the 420 MME recommended by the pain specialist. Respondent did not explain why she did not follow the pain specialist's recommendations to reduce P-4's total opioid dosage by 10% a month or, failing that, to arrange for inpatient rehabilitation and did not develop a specific long-term plan for how and by how much to taper P-4's opioid and/or other medications. Throughout her treatment of P-4, Respondent did not follow through in any consistent way with even her vague non-specific tapering plans.

51. On November 17, 2017, Respondent noted that P-4 was "[s]leeping at night now" and wrote "Restoril not working well anymore." Nonetheless, even recognizing the danger of combining benzodiazepines with opioid medications, she continued prescribing Restoril through at least July 2018, the last date for which records are available.

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[27] Ambien, a trade name for zolpidem tartrate, is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Dosage adjustment may be necessary when zolpidem tartrate is combined with other central nervous system depressant drugs because of the potentially additive effects. Zolpidem tartrate is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

52. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), and/or section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or repeatedly prescribed excessively and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent prescribed excessive amounts of opioid medications and benzodiazepines for Patient P-4 placing him at risk of overdose and death.

B. Respondent failed to monitor closely the dangerous combination of temazepam (Restoril), zolpidem (Ambien), and opioid medications and to adjust them to ensure safety.

C. Respondent failed to taper Patient P-4's opioid medications or to refer him to an inpatient rehabilitation program as recommended by the pain management specialist.

D. Respondent repeated paragraphs verbatim from visit to visit in her chart notes for Patient P-4 and included confusing and misleading information in the notes leading to confusion as to the facts and circumstances of her treatment of Patient P-4.

E. Respondent failed to develop and follow through on a treatment plan regarding the taper of the controlled substances she was prescribing for Patient P-4.

PATIENT P-5

53. Respondent assumed the care of Patient P-5, then 46 years old, in October 2015 and continued treating him until at least 2018. She saw him on a regular basis and treated him for, among other comorbidities, spondylolisthesis and chronic pain. Respondent wrote in her chart notes for P-5's first visit on October 14, 2015 that P-5 told her that he had been on 6 tablets daily of hydromorphone 6 mg and 6 tablets daily of oxymorphone[28] 40 mg until approximately two

[28] Oxymorphone, also known by the trade name Opana ER, is an opioid pain medication used to treat moderate to severe pain. The extended-release form of this medication is for around-the-clock treatment of pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by Health and Safety Code section 11055. It is three times as potent as morphine.

months prior when his dosages were cut to 2 tablets of each a day. Respondent's chart notes, however, also contain the contradictory information that P-5 had received 270 tablets of hydromorphone 4 mg on July 28, 2015, 180 tablets on August 26, 2015, and 150 tablets on September 24, 2015. (This information was repeated in her chart notes through at least January 2016.) So it is not clear how much hydromorphone and oxymorphone P-5 was actually taking. P-5 had apparently also been taking 3 mg of alprazolam twice a day. Despite noting that P-5 presented with pressured speech and run on sentences and very tangential, disorganized thoughts and that his high dose of oxymorphone and alprazolam might be contributing to his cognitive dysfunction, Respondent continued prescribing high doses of both. She prescribed 6 tablets of hydromorphone 4 mg,[29] 6 tablets of oxymorphone 40 mg, 6 mg of alprazolam, and 10 mg of nortriptyline daily noting that the opioid equivalent—MME— for the oxymorphone alone was 720, "WAY above state guidelines for opioid therapy." She repeated this exact language in her chart notes throughout most of the time she treated P-5. She also repeated verbatim the statement, "[w]e will resume dilaudid 6 per day for now" in both this chart note and the chart note for December. There are many such examples of statements repeated verbatim from visit to visit such as the November 12, 2015 comment, "recent and remote memory intact; less pressured speech today and appears more relaxed and focused" which is found in nearly every chart note from November 12, 2015 through February 1, 2018. Large quantities of repetitious historical information were also carried forward from visit to visit.

54. Respondent wrote in her October 21, 2015 chart notes, "[o]ver time I would recommend we work on tapering the alprazolam – there are other alternatives for anxiety," but did not develop a plan for decreasing the medication. On November 12, 2015, Respondent wrote "[d]oing well on reduced numbers of controlled rxs" but did not identify which prescriptions were reduced and by how much. In fact, she was prescribing the same amounts of opioid medications

[29] The Informed Consent Agreement for Treatment of Intractable Pain with Narcotics that P-5 signed the same day states that he has been prescribed 5 tablets daily of hydromorphone 4 mg.

she had prescribed the previous month—24 mg a day of hydromorphone 4 mg and 240 mg of oxymorphone 40 mg for an MME of 816.

55. Respondent continued prescribing this amount until February 1, 2016 when P-5 asked about replacing some of his hydromorphone with levorphanol[30] because his insurance company was giving him "a hard time about the current medications and getting refills in a timely manner." Respondent noted that she did not have experience using the medication but that P-5 had brought her an article and she had done a quick literature search. She wrote, "I will investigate the levorphanol and the possible conversion of [P-5's] hydromorphone to levorphanol" but nonetheless prescribed a month's supply at that visit. Because the opioid equivalence calculators she used gave "remarkably" different results, she directed P-5 to begin with 2 tablets a day but advised that he could increase by 1 tablet every 3 days to a maximum of 5 per day.

56. On March 16, 2016, Respondent worked P-5 in for an urgent visit because he was not doing well on his current medication regimen and had stopped taking the levorphanol. He advised Respondent that, although morphine equivalency calculators show that levorphanol is between 4 and 12 times as potent as morphine, his further research showed that levorphanol had only one-tenth the pain relief of opioids and had very high serotonin. Respondent again prescribed hydromorphone 8 mg in a large enough quantity for P-5 to take up to 24 mg daily, his previous dose, and added gabapentin,[31] another sedating medication, without explaining why.

57. On April 28, 2016, Respondent noted that P-5 had gotten a second degree burn lighting his stove with lighter fluid and was treated by an emergency room doctor friend. Respondent did not investigate this red flag that P-5's medications might have been affecting his ability to function. Respondent, in fact, increased his dose of gabapentin.

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[30] Levorphanol tartrate is a potent synthetic opioid analgesic indicated for the management of moderate to severe pain. Levorphanol is similar to morphine in its actions, however it is up to 12 times more potent than morphine. Levorphanol produces a degree of respiratory depression similar to that produced by morphine at equianalgesic doses, and like many mu-opioid drugs, levorphanol produces euphoria or has a positive effect on mood in many individuals. Levorphanol is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code.

[31] Gabapentin, also known by the trade name Neurontin, is a nerve pain medication and anticonvulsant. It is indicated for treatment of seizures and neuropathic pain caused by shingles. It is a CNS depressant. Gabapentin is a dangerous drug as defined in section 4022.

58. On April 28, 2016, Respondent wrote that P-5 was down to 4 mg a day of alprazolam. One month later, on May 26, 2016, she noted that he was down to 5 mg of alprazolam per day.

59. P-5 advised Respondent on May 26, 2016 that he wanted to reduce the dose of gabapentin because he had been told that he had some slurred speech and odd behavior while on it. Respondent simply noted this and did not comment on it or document having investigated other possible causes for the behavior. At the same visit, Respondent noted that P-5 had a necrotic hematoma on the inner aspect of his left upper arm which he said was the result of a fall. This is a red flag for intravenous drug use and Respondent did not document having addressed or ruled out this possibility.

60. On July 27, 2016, P-5 reported to Respondent that he had accidentally washed a strip of his oxymorphone in his pants pocket and the pills dissolved. He produced several half dissolved tablets for inspection. Respondent documented a "one time replacement of tablets accidentally washed." Respondent was still prescribing the same amount of opioids as when she began treating P-5: 24 mg of hydromorphone and 240 mg of oxycodone daily for a total MME of 816.

61. On February 7, 2017, P-5 once again reported that his medications had been rendered unusable, this time by the cold and a water leak in his home. Once again Respondent noted that she would replace his medications "one time." She wrote that she "reinforced terms of contract." The contract provided that, "Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication." Respondent had increased the amount of hydromorphone she was prescribing for P-5 for several months at the end of 2016/beginning of 2017 so that he could "develop a small reserve" but at this time, was once again prescribing the same amounts of hydromorphone and oxymorphone as she had been when she began treating P-5.

62. Respondent noted in her chart notes for P-5's March 16, 2017 visit, that the pharmacy claims that P-5 picked up the full prescription of his medication twice, on February 15, 2017 and again on February 21, 2017. Respondent contacted the pharmacy and received a letter from the pharmacist appending the complete results of an investigation along with pertinent documentation reflecting that P-5 did pick up two oxymorphone prescriptions. Respondent chose to believe P-

5's claim that the pharmacy was in error and prescribed 4 tablets daily of MS Contin[32] 60 mg to tide him over until his next refill could be dispensed.

63. On April 13, 2017, P-5 reported that the MS Contin had not been lasting 12 hours as planned so he had been taking it every 8 hours and had to dip into his hydromorphone. Respondent noted that she would not fill his hydromorphone early and hoped that she could taper the hydromorphone after this since he would be off of it for a while. Nonetheless, when his next prescription came due on April 27, 2017, she prescribed the same amount of hydromorphone as before.

64. Respondent was still prescribing the same amounts of hydromorphone and oxymorphone for P-5 on September 14, 2017 when she noted that she hoped to "taper hydromorphone after this, now that travel is done," on October 4, 2017 when she noted that she hoped to "taper hydromorphone after this, now that travel is done, dental work is done," and on November 9, 2017 when she noted that she hoped to "taper hydromorphone next month, now that travel is done, dental work is done." Respondent also noted on November 9th that P-5 had run out of hydromorphone at the time of his last visit.

65. On December 7, 2017, Respondent finally began slowly tapering P-5's hydromorphone dosage. She also initiated a slow taper of alprazolam from 3 mg a day to 2-1/2 mg a day. On April 26, 2018, she began a slow taper of P-5's oxymorphone. By July 19, 2018, P-5's MME was reduced but still very high at 664 and her alprazolam dosage was 2.25 mg daily.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

66. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), and/or section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or

[32] MS Contin, a trade name for morphine sulfate extended-release tablets, is a strong pain medicine that contains an opioid (narcotic) that is used to manage pain severe enough to require daily around-the-clock, long-term treatment with an opioid. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code.

repeatedly prescribed excessively and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent prescribed excessive amounts of opioid medications and benzodiazepines for Patient P-5 throughout the years she cared for him, failing to taper his medication significantly despite red flags and his failure to comply with his pain medication contract.

B. Respondent failed to appropriately adjust her treatment plans for Patient P-5 based on information learned during his regular visits with her.

C. Respondent's treatment plans for Patient P-5 are not always clear, sometimes lack logical follow-through, and on a number of occasions were altered in deference to P-5's assessments and preferences.

D. Respondent repeated paragraphs verbatim from visit to visit in her chart notes for Patient P-5 making it difficult to know when an event occurred and carried forward excessive amounts of historic information making it hard to cull out the new information.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51185, issued to Corinne Vivian Basch, M.D.;

2. Revoking, suspending or denying approval of Corinne Vivian Basch, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Corinne Vivian Basch, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 8, 2019

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

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