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

In the Matter of the Accusation Against: Denise Anh-Duong Phan, M.D. Physician's & Surgeon's Certificate No G73973 Respondent	Case No. 800-2017-035186

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 12, 2021.

IT IS SO ORDERED January 14, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

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

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

In the Matter of the Accusation Against:

DENISE ANH-DUONG PHAN, M.D.

Physician's and Surgeon's Certificate No. G 73973,

Respondent

Agency Case No. 800-2017-035186

OAH No. 2019110622

PROPOSED DECISION

Julie Cabos-Owen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on November 16, 17, and 18, 2020. William Prasifka (Complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, was represented by Christina Sein Goot, Deputy Attorney General. Denise Anh-Duong Phan, M.D. (Respondent) appeared and was represented by Peter R. Osinoff, Attorney at Law with Bonne, Bridges, Mueller, O'Keefe & Nichols.

At the hearing, the ALJ was provided with Exhibits 7, 8, 9, 10, 11, 12, and 21, which contained confidential medical and personal information. However, redaction of

Exhibits 7, 8, 9, 10, 11, 12, and 21 to obscure confidential information was not practicable and would not provide adequate privacy protection. In order to prevent the disclosure of confidential information, concurrent with the issuance of this Proposed Decision, the ALJ issued a Protective Order placing Exhibits 7, 8, 9, 10, 11, 12, and 21 under seal. These exhibits shall remain under seal and shall not be opened, except by order of the Board, by OAH, or by a reviewing court. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee, under Government Code section 11517, may review the documents subject to this order, provided such documents are protected from release to the public.

At the administrative hearing, the Accusation (Exhibit 1) was amended as follows: at paragraph 18, line 5, after the word "benzodiazepines," the words "and by failing to refer Patient 1 to a psychiatrist" were stricken; and at paragraph 19, line 12, after the sentence ending with the word "history," the words "For example," were added prior to the words "it did not."

Testimony and documentary evidence was received. The record was closed and the matter was submitted for decision on November 18, 2020.

FACTUAL FINDINGS

Jurisdictional Matters

1. On April 28, 1992, the Board issued Physician's and Surgeon's Certificate Number G 73973 to Respondent. That the license is scheduled to expire on December 31, 2021.

2. On June 17, 2019, Kimberly Kirchmeyer filed the Accusation while acting in her official capacity as the then Executive Director of the Board. Respondent filed a Notice of Defense, and this hearing ensued.

Treatment of Patient 1[1]

3A. Patient 1 was a 53-year-old female who began treating with Respondent on March 28, 2011.[2] At that time, Patient 1 was also under the care of other medical specialists/consultants, and she was taking numerous medications.

3B. Respondent practices internal medicine, and she provided treatment as Patient 1's primary care physician.

3C. At that first visit, Respondent noted Patient 1's history of present illness (HPI) as follows:

> [H]ere for new patient evaluation with multiple problems. Patient had acute onset diarrhea 2009 and severe weight loss. . . . [G]ot endoscopy and colonoscopy CT scan showed thickening consistent with ulcerative colitis vs cancer,

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[1] The patient is identified by a number to preserve confidentiality.

[2] Business and Professions Code section 2230.5, subdivision (a), precludes discipline for acts and omissions which occurred more than seven years prior to the filing of the Accusation on July 17, 2019. The Accusation alleges facts occurring prior to July 17, 2012. However, any background facts herein describing occurrences prior to July 12, 2012, are contextual and not bases for any disciplinary action.

> colonoscopy went only up to transverse colon and showed normal, endoscopy showed gastritis. Still didn't get any therapy. Patient now has bowel incontinence and can't go anywhere due to diarrhea unless she stops eating 24 hours in advance. Imodium causes constipation and has to take laxatives.
>
> History of low potassium, [and] has to take potassium pills every day.
>
> Also seen a cardiologist for heart murmur, found to have bicuspid aortic valve with stenosis, pulmonary hypertension, thoracic aortic aneurysm at 3.5 cm. Need cardiology follow up.
>
> Patient being seen by Dr. Khavari for management of systemic lupus erythematosus and fibromyalgia and knees pain status post work accident in 2007 which caused meniscus tear and subsequent surgery which did not work partially because patient was not told what to do after surgery. This led to loss of job then divorce and bankruptcy. Very stressed and depressed.

(Exhibit 10, p. 347 [e-p. 422][3].)

[3] In addition to citing the exhibits' internal page numbers, the .pdf page within the electronically-filed exhibits is provided in brackets for ease of reference.

3D. Respondent noted that Patient 1 worked as a nurse before her disability and that she was on a vegan diet for 28 years until her recent weight loss. At the first visit, the patient, who was five feet, four inches tall, weighed 91 pounds. In her assessment, Respondent documented the following: "bilateral knees pain – due to injury; hip pain; low back pain; neck and shoulders pain; hypokalemia [i.e., low potassium]; diarrhea; systemic lupus erythematosus; fibromyalgia; [and] depression." (Exhibit 10, p. 348 [e-p. 423].)

3E. During the first visit, Respondent requested prior labs and records, and referred Patient 1 to a cardiologist and to a gastroenterologist. Respondent also prescribed Norco 10/325 mg (10 mg Hydrocodone with 325 mg acetaminophen),[4] four times per day "as needed for pain." (*Id.* at p. 349 [e-p. 424.].)

4. During the second visit on June 9, 2011, Patient 1 reported a history of chronic constipation for which she had been taking laxatives and stool softener, but she had reduced her use of stool softener due to diarrhea. In documenting the patient's HPI, Respondent noted: "Patient also needs refill on Norco for occasional use for systemic lupus erythematosus, knee and back pain. Norco usually doesn't constipate her but gives her diarrhea. Also complains of stress due to personal and financial issues. Does not want Prozac medications yet, just something for episodic use. Valium worked for her before." (Exhibit 10, p. 314 [e-p. 389].) Respondent's plan

[4] Hydrocodone is an opioid used to treat pain. Acetaminophen is generic Tylenol.

included refilling the Norco prescription (60 tablets) and adding Valium 5 mg every 12 hours as needed (30 tablets).[5]

5. On June 23, 2011, Patient 1 was seen in follow up, and Respondent noted that the patient was losing more weight, had no appetite, was vomiting after meals, and could not tolerate Ensure due to nausea. The patient's weight had gone down to 81 pounds. Patient 1 reported that she "has not taken Norco at all past 2 weeks because she is trying to save it." (Exhibit 10, p. 302 [e-p. 377].) Respondent noted Patient 1's chronic gastrointestinal (GI) problems as possible irritable bowel syndrome (IBS), and the patient's need for a thorough GI work up. Respondent also noted Patient 1's severe weight loss, "painful fibroma, insomnia [and] systemic lupus erythematosus." (Exhibit 10, p. 303 [e-p. 378].) The patient refused hospital admission for excessive weight loss. Respondent's plan included medications and treatments focused on the patient's GI problems. Respondent noted it was "okay to take Norco as need for pain," and she prescribed temazepam 15 mg at bedtime (30 tablets),[6] and Seroquel 100 mg at bedtime "for insomnia and appetite."[7] (Exhibit 10, p. 304 [e-p. 379].) Respondent also provided Patient 1 with samples of Lunesta.[8]

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[5] Valium (brand name for generic diazepam) is a benzodiazepine used to treat anxiety disorders.

[6] Temazepam (generic for brand name Restoril) is a benzodiazepine used to treat insomnia.

[7] Seroquel (brand name for quetiapine) is an antipsychotic which can be used with antidepressant medications to treat major depressive disorder in adults.

[8] Lunesta is a sedative used to treat insomnia.

6. On June 30, 2011, Respondent saw Patient 1 in follow up. The patient's abnormal weight loss had reversed, and she weighed 96 pounds. However, she complained of "hurting all over." (Exhibit 10, p. 292 [e-p. 367].) Respondent noted Patient 1's insomnia had improved with Restoril.

7. On July 25, 2011, Patient 1 returned to Respondent in follow up complaining of dizziness and lack of energy, which she attributed to a Boniva infusion by her rheumatologist the prior month. Her GI problems were better, and she was gaining weight until the prior week when one of her GI medications ran out. Her weight at the July 25, 2011 visit was 80 pounds. Respondent spoke with the patient about the possibility of anorexia nervosa. Respondent continued the patient on her GI medications and refilled her temazepam prescription as needed for sleep.

8. In early August 2011, Patient 1 fell and fractured her femur, two vertebrae, and her knee. She was hospitalized and, on August 12, 2011, she underwent surgery at USC performed by Daniel Allison, M.D. Patient 1 was later discharged home with home health care from about August 19, 2011 through early October 2011. The home medications prescribed for her included Ativan,[9] Ambien,[10] and Klonopin.[11] On

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[9] Ativan (brand name for generic lorazepam) is a benzodiazepine used to treat anxiety disorders and seizure disorders.

[10] Ambien (brand name for generic zolpidem) is a sedative used to treat insomnia.

[11] Klonopin (brand name for generic clonazepam) is a benzodiazepine used to treat seizure disorders and panic disorders in adults.

August 29, 2011, Respondent spoke with Patient 1 by telephone. The patient reported poor pain control but improved weight gain.

9A. On October 10, 2011, Patient 1 saw Respondent in follow up for the first time after her fall and fractures (sacral and knee). She was eating well and weighed 103 pounds. She reported a bilateral foot drop after surgery for which she was told to follow up with a neurologist but had been unable to do so while homebound. Patient 1 also complained of severe low back pain in the sacral area. She ran out of Norco but had been taking over the counter pain medications with only mild pain relief. Patient 1 continued to suffer from insomnia, and she complained of severe anxiety and fear of leaving the house due to the possibility of falling. Patient 1 asked for prescriptions for Ambien and Ativan, the latter of which she reported calmed her down without causing sedation or imbalance. She also asked about which antidepressant would be appropriate for her.

9B. Respondent noted the patient's recent fractures, bilateral foot drop, osteoporosis, systemic lupus erythematosus, anxiety/depression, insomnia, fibromyalgia, improved IBS, and low potassium. Respondent's plan for treatment included follow up with rheumatologist, Dr. Khavari, and referral to a neurologist. Respondent prescribed Norco 10 mg every six hours as needed, Ativan 2 mg twice per day, Ambien 10 mg once per day, and she noted, "consider Cymbalta[12] which will

[12] Cymbalta (brand name for generic duloxetine) is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressant used to treat major depressive disorder and general anxiety disorder. It can also be used to treat nerve pain, chronic muscle or joint pain, and fibromyalgia.

help with anxiety / depression, fibromyalgia and maybe low back pain. Patient will check with rheumatology." (Exhibit 10, p. 254 [e-p. 329].)

10. On November 14, 2011, Patient 1 saw Respondent in follow up. At that visit she weighed 116 pounds. Respondent refilled the patient's Ambien, Ativan, and Soma (a muscle relaxer) 350 mg as needed. She also refilled the patient's Norco (120 tablets), to be taken every four hours as needed.

11A. On about November 9, 2011, Anthem Blue Cross Prescription Drug Plan sent a letter to Respondent alerting her that Patient 1 "has filled 10 or more prescriptions for controlled substances within 3 months" from multiple providers and noting "potential medication-related issues such as appropriate use, compliance, safety concerns, and cost-savings opportunities." (Exhibit 10, pp. 228, 230 [e-pp. 303, 305].) The prescriptions Patient 1 filled included: on July 28, 2011, hydrocodone/acetaminophen 5/500 (100 tablets), prescribed by Steven York; on August 18 and 19, 2011, hydromorphone 2 mg (30 tablets),[13] zolpidem 5 mg (30 tablets), and lorazepam 1 mg (30 tablets), prescribed by "unknown"; on September 9, 2011, hydromorphone 2 mg (90 tablets), prescribed by Daniel Allison; on October 10, 2011, hydrocodone/acetaminophen 10/325, prescribed by Daniel Allison; on October 15, 2011, lorazepam and zolpidem, prescribed by "unknown"; and on October 21, 2011, hydromorphone 2 mg (120 tablets), prescribed by Daniel Allison. (Exhibit 10, p. 231 [e-p. 306].)

[13] Hydromorphone (generic for brand name Dilaudid) is an opioid used to treat pain.

11B. Respondent received and reviewed the letter, but she did not see it prior to Patient 1's November 14, 2011 visit. Respondent sent back a form provided by Anthem Blue Cross indicating that the "drug regimen is appropriate for this patient," and noting "patient had major trauma & underwent multiple orthopedic surgeries past few [months]." (Exhibit 10, pp. 230, 231 [e-pp. 305, 306].)

12. On January 17, 2012, Patient 1 visited Respondent. The patient was still underweight at 112 pounds. She reported that she had fallen and fractured her back, and she complained of sciatica pain radiating down her left leg while standing, walking, and lying down. Patient 1 informed Respondent that taking Norco every four hours helped. However, she wanted to discuss pain management, noting that she had been taking Norco since 2007 and believed she was developing a tolerance to it. Respondent prescribed MS Contin 15 mg twice per day (60 tablets).[14]

13. On about January 19, 2012, Patient 1 was seen by Peter Brian Andersson, M.D., Ph.D., who was Board certified in neurology and clinical neurophysiology. On that date, Dr. Andersson sent Respondent a Neurology Outpatient Report, noting that Respondent had referred Patient 1 to him with weakness, pain, and numbness. Dr. Andersson also noted Patient 1's reported history of seizures, and he opined that these "sound metabolic rather than a primary myoclonic epilepsy. [He] advised against anticonvulsant or benzodiazepine therapy until there is more objective evidence. Morphine is associated with myoclonic jerks although she reports she is only been taking this for days." (Exhibit 10, p. 215 [e-p. 290].)

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[14] MS Contin (brand name for generic morphine) is an opioid medication used to treat moderate to severe pain.

14. On February 25, 2012, Patient 1 saw Respondent and reported she was in a lot of pain. She informed Respondent she took MS Contin and Percocet[15] but these medications did not help control her pain. She found Norco best eased her pain but did not eliminate it. She liked Norco's low acetaminophen dosage because she had concerns regarding its effect on her liver and chronic hepatitis. Respondent continued Patient 1's Norco (240 tablets), prescribing two tablets every four hours.

15. Patient 1 saw Respondent again on March 14, 2012, April 19, 2012, and June 26, 2012. Patient 1 continued to complain of pain, insomnia, and anxiety. At each of the appointments, Respondent continued Patient 1's Norco (240 tablets), prescribing two tablets every four to six hours. Respondent also continued Patient 1's Ativan.

16. Patient 1 saw Respondent again on August 27, 2012, September 27, 2012, October 29, 2012, and November 26, 2012. At those visits, Patient 1 continued to complain of various pain, including pain in her left knee radiating down her left leg with no sciatica (on 8/27/12), pain in her legs and arms (on 9/27/12), low back tenderness and tightness (on 10/29/12), and pain in her knees and lower legs with no sciatica (on 11/26/12). She also complained of extreme anxiety and depression. At each of these appointments, Respondent continued Patient 1's prescriptions for Norco (2 tablets every six hours) and Ativan.

17. On December 20, 2012, Patient 1 visited Respondent and she complained of feeling "pain almost all the time some days worse than others, and anxiety all the

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[15] Percocet (brand name for generic oxycodone / acetaminophen) is an opioid medication used to treat pain.

time even on Norco 'around the clock' and Ativan." (Exhibit 10, p. 82 [e-p. 156].) She also complained of severe headaches. Respondent's assessment included diagnoses of fibromyalgia, anxiety and depression, post-traumatic arthritis, and systemic lupus erythematosus. Respondent changed the patient's Ativan prescription to clonazepam 1mg two times per day, and she continued the patient's Norco prescription, two tablets every four hours as needed (240 tablets). Respondent also prescribed Dilaudid 4 mg every six hours as needed for breakthrough pain (100 tablets).

18. On January 28, 2013, Patient 1 returned to Respondent for follow up. Patient 1 reported that the "combination of clonazepam, Norco, Prozac and Dilaudid helped calm down everything; her anxiety about going outside, myoclonic seizures, her tinnitus, her diarrhea, her pressured speech, less coldness and tightness of bilateral hands and less posturing of feet." (Exhibit 10, p. 72 [e-p. 146].) Respondent's assessment included diagnoses of anxiety, insomnia, systemic lupus, viral hepatitis, and "somatoform pain syndrome." (*Id.* at p. 74 [e-p. 148].) Respondent continued the patient's medications including Norco and clonazepam but changed Ambien to trazodone at bedtime. Respondent also changed the patient's Dilaudid prescription to 8 mg three times per day (100 tablets), and she noted the patient "may cut down on Norco if less pain." (*Ibid.*)

19. On February 28, 2013, Patient 1 visited Respondent for a scheduled complete physical examination, but she also had several new complaints. Patient 1 reported falling three weeks prior and complained of increased low back pain. She also weighed 116 pounds and was trying to gain weight after stomach flu in January. Respondent reduced the patient's Dilaudid to 4 mg three times per day and continued the patient's Norco (240 tablets) and clonazepam.

20. On March 28, 2013, Patient 1 returned to Respondent complaining of pain all over, including "lower extremity tightness" and "right wrist tendonitis." (Exhibit 10, p. 45 [e-p. 119].) She reported that Dilaudid helps ease the pain but made her "loopy." (*Ibid.*) Patient 1 again reported that Norco alone helped with pain but did not completely alleviate it. However, she wanted to try a medication that did not contain acetaminophen due to her chronic hepatitis. Respondent documented the patient's weight at 113 pounds. Respondent's assessment included diagnoses of fibromyalgia, systemic lupus erythematosus, and insomnia. Respondent prescribed a trial use of oxycodone[16] 30 mg four times per day as needed for breakthrough pain (100 tablets), and she refilled the patient's Norco, two 10 mg tablets four times per day (240 tablets). Respondent also recommended increasing the trazodone dosage to 1.5 tablets for sleep aid.

21. On April 29, 2013, Patient 1 visited Respondent and reported her medication regimen was working well to help her sleep, control her depression and manage her pain. However, Respondent noted the patient was losing weight, and documented her weight at 107 pounds. Her assessment included weight loss, systemic lupus, fibromyalgia, and lumbar spine degenerative disc disease. Respondent continued the patient's medications including the clonazepam, oxycodone as needed for breakthrough pain, and Norco two 10 mg tablets four times per day (240 tablets).

22. On May 28, 2013, Patient 1 returned to Respondent in follow up. Respondent noted the patient's continued low weight at 100 pounds, and she also noted that the patient's pain syndrome was controlled on regimen of Norco and

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[16] Oxycodone (generic for brand names OxyContin and Roxicodone) is an opioid pain medication used to treat moderate to severe pain.

oxycodone. However, Patient 1 again expressed concern about being on the medications for a long time, and she asked about other options for chronic pain. Respondent's assessment included weight loss, systemic lupus erythematosus, fibromyalgia, knee osteoarthritis, and insomnia. Respondent refilled the patient's prescriptions for clonazepam, oxycodone four times per day as needed for breakthrough pain (100 tablets), and Norco, two 10 mg tablets four times per day (240 tablets). Respondent also noted in her chart note, "consider fentanyl [[17]] patch or oxycontin for chronic use with Norco for breakthrough." (Exhibit 10, p. 24 [e-p. 98].) Respondent testified credibly at the administrative hearing that, at this visit, she discussed with Patient 1 the risks and benefits of using the fentanyl patch, and (as documented in the chart) the patient indicated that she would research her insurance coverage for that medication.

23A. July 1, 2013 was Patient 1's last visit with Respondent. At that visit, Patient 1 complained of falling in her home again the prior day. She stated that she was "now agreeable with going on fentanyl so she can go off Norco in order to reduce Tylenol amount. Will be using oxycodone for breakthrough pain." (Exhibit 10, p. 8 [e-p. 82].) Respondent also noted "unfortunately, patient fell at home yesterday and has been having pain in the left pelvic area near where she had the pelvic fracture before." (*Ibid.*) On this date, the patient's weight was down to 98.5 pounds.

23B. Respondent's assessment included pelvic pain status post fall, systemic lupus erythematosus, fibromyalgia, insomnia, and constipation/weight loss – possible

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[17] Fentanyl is an opioid pain medication used to treat severe chronic pain, typically delivered via a patch placed on the patient's skin which releases continuous analgesia lasting three days.

irritable bowel syndrome. Respondent refilled the patient's prescriptions for clonazepam and for trazodone and Topomax[18] "for migraine and insomnia." Respondent also provided Patient 1 with a trial of Pamelor[19] "for IBS," and documented in the chart that she cautioned Patient 1 to "watch for increase dry mouth due to trazodone plus Pamelor." (Exhibit 10, p. 10 [e-p. 84].)

23C. Respondent refilled the patient's prescription for oxycodone for breakthrough pain, without change in the dosage. She also issued a new prescription for a fentanyl patch 100 mcg every three days (10 units) to replace the patient's Norco prescription.

23D. (1) Unlike Respondent's documentation of the side effects of Pamelor use with trazedone, there was no documentation in Patient 1's chart that Respondent had counseled Patient 1 about the safety precautions for use, and the potential side effects, of fentanyl.

(2) At the administrative hearing, Respondent testified that, on July 1, 2013, she advised the patient about the dangers of heat exposure to the patch and warned her against using a heating pad, sauna, and heated blankets. She testified that she also informed Patient 1 that the analgesic effect of the patch could take 12 to 24 hours. This recollection was self-serving and was questionable given the lack of documentation of the cautions, which differed from Respondent's documentation of

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[18] Topomax is the brand name for generic topiramate, an anticonvulsant used to treat seizures and also to prevent migraine headaches.

[19] Pamelor is the brand name for generic nortriptyline, an antidepressant typically used to treat depression.

the adverse effects of the other medications (Pamelor taken with trazedone) she provided on the same date. Therefore, Respondent's recollection of her fentanyl advisements to the patient on July 1, 2013, are given no weight. Nevertheless, this does not conversely establish, by clear and convincing evidence, that Respondent did not make these advisements.[20]

24. On July 1, 2013, Respondent had little prior experience prescribing the fentanyl patch, having prescribed it to only two previous patients. In prescribing the 100-mcg fentanyl patch to Patient 1 as a replacement for her Norco prescription, Respondent used a dosing table to convert the equivalent amount of hydrocodone (in the Norco) to fentanyl. Respondent's dose conversion and prescription of the 100-mcg dosage of fentanyl was incorrect. The correct dose conversion from the patient's Norco (20 mg every six hours) to the fentanyl transdermal patch was the 50-mcg fentanyl patch.

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[20] The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. "Disbelief does not create affirmative evidence to the contrary of that which is discarded. The fact that [the trier of fact] may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative." (*Hutchinson v. Contractors' State License Bd. of Cal.* (1956) 143 Cal.App.2d 628, 632, citing *Marovich v. Central Cal. Traction Co.* (1923) 191 Cal.295, 304.)

25. Patient 1 was found dead in her home on July 4, 2013. The fentanyl patch was affixed to her arm. According to the autopsy report, Patient 1 died from acute fentanyl and oxycodone toxicity.[21]

The Experts

26A. Complainant offered the expert report and testimony of Mark Ackerman, M.D., to establish the standard of care for the treatment of the patient in this case. Dr. Ackerman obtained his medical degree from the State University of New York at Stony Brook in 1994. He completed an internal medicine residency at St. Mary's Medical Center in San Francisco, California in 1997. Dr. Ackerman is licensed to practice medicine in California, and he received certification with the American Board of Internal Medicine in 2007 and in 2017. From 1998 through 2006, he worked in San Francisco as a staff physician at On Lok Senior Health, an Assistant Clinical Professor of Medicine at the University of California, San Francisco (UCSF), and as a Clinical Instructor in the St. Mary's Medical Center Department of Medicine. In 2006, he moved to Los Angeles, and he is currently an Assistant Clinical Professor of Medicine at the University of California, Los Angeles (UCLA) - David Geffen School of Medicine, a full-time staff physician at the Arthur Ashe Student Health and Wellness Center at UCLA, and a medical consultant for the Board.

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[21] There was testimony from both parties' experts regarding the accuracy of the stated cause of death. This decision will not address whether the autopsy report accurately stated the cause of death since there was no expert testimony from any medical examiner to contradict the stated cause of death and since there is no allegation in the Accusation that Respondent caused Patient 1's death.

26B. (1) Respondent offered the expert report and testimony of Standiford Helm, II, M.D., M.B.A., to establish the standard of care for the treatment of Patient 1. After graduating, magna cum laude, from Harvard College, Dr. Helm obtained his medical degree from Tufts University in 1977. He completed an anesthesiology residency UCLA in 1980. Dr. Helm is certified by the American Board of Anesthesiology (1982 through present), with a subspecialty certification in Pain Medicine. He is licensed to practice medicine in California, and since 2000 he has practiced full time as a pain management specialist. Although he specializes in pain management, Dr. Helm is familiar with the standard of care for primary care physicians (PCPs) and internal medicine physicians prescribing controlled substances in 2012-2013 because PCPs have been his primary source of referral, and he has reviewed numerous PCP records.

(2) Dr. Helm is the Medical Director of The Helm Center for Pain Management in Laguna Woods, California. Dr. Helm has been an active participant and leader in numerous organizations dealing with pain medicine, including the American Academy of Pain Medicine, the California Academy of Pain Medicine, the American Board of Interventional Pain Physicians, the American Society of Interventional Pain Physicians, and the World Institute of Pain. He sits on the editorial boards of several medical publications and journals addressing pain medication issues, including the Pain Physician Journal. He has given numerous lectures and published extensively on the topic of pain management.

26C. Drs. Ackerman and Helm were both qualified to testify as experts regarding the standard of care in this case which involves the practice of internal medicine in 2012 and 2013. Any additional weight given to one expert's testimony over the other's was based on the content of their testimony and bases for their opinions, as set forth more fully below.

Standard of Care

GROSS NEGLIGENCE

27. Complainant alleged that Respondent engaged in gross negligence in her care and treatment of Patient 1. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197.) 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.)." (*Gore v. Bd. of Med. Quality Assurance* (1980) 110 Cal. App. 3d 184, 198.)

28. Dr. Ackerman testified credibly and without contradiction that a physician should take care in prescribing narcotics to patients because such medications can be lethal, have many side effects, and are prone to abuse.

29. Both Drs. Ackerman and Helm agreed that Respondent used an erroneous calculation to convert hydrocodone to fentanyl, that she prescribed an incorrect fentanyl dosage, and that she should have prescribed the 50-mcg fentanyl patch. They also agreed that Respondent's error was a departure from the standard of care. However, they disagreed on whether her error was a simple departure or an extreme departure from the standard of care (i.e., simple negligence or gross negligence).

30A. Dr. Ackerman asserted that, in 2013, it was known in the medical community that there was an inconsistency in the available opioid conversion tables which created a risk of patient deaths. To substantiate his assertion, Dr. Ackerman

cited two articles, including a 2012 article in the journal, Pain Medicine, which noted that the use of dose conversion calculations published in equianalgesic tables could lead to fatal or near-fatal opioid overdoses. The 2012 article pointed out that many physicians were incorrectly using the tables and that, even with user training and accurate use, the opioid conversion tables could be inherently flawed when used in opioid rotation, leading to potentially fatal outcomes. The 2012 article also pointed out, "There is no acceptable level of medically prescribed opioid dosing error, especially when toxicity can and does lead to fatality." (Exhibit 17, p. 7 [e-p. 556].)

30B. Dr. Helm had authored a 2008 journal article stating that opioid conversion tables were unreliable. However, he disagreed that the flaws in the conversion tables were well known in the medical community in 2013. He opined that, while some pain management physicians were aware of this issue, and it was later noted in 2012 and 2013 articles in pain management medical journals, this problem "wasn't obvious," and a lot of physicians "had not gotten the message in 2013."

30C. At the administrative hearing, Respondent testified that she had a special interest in the field of pain management, and in 2004, she had undergone pain management training and consulted with a mentor, Dr. Rasool, for about one year. According to Respondent, at the time she prescribed Patient 1's fentanyl patch, she was "going to multiple seminars on pain, chronic pain, and opiate use," had been "taught to use the equianalgesic tables," and "felt comfortable" prescribing fentanyl. She asserted that her incorrect calculation for the fentanyl patch dosage was actually correct according to the conversion table she had obtained at a seminar. Although Respondent recalled the seminar she attended was presented online, she maintained that when she "went to the webinar," the conversion table given to her was "on paper." However, Respondent could not produce the conversion table she used for calculation

of Patient 1's fentanyl dosage. It was therefore impossible to verify Respondent's self-serving assertion that her miscalculation resulted from the conversion table's inaccuracy rather than her improper use of the table.

30D. It was not established, by clear and convincing evidence, that in 2013, PCPs and internal medicine physicians such as Respondent should have known that many of the equianalgesic tables were unreliable for converting dosages. It was also not established by the evidence that the table Respondent used for determining Patient 1's fentanyl dosage was inaccurate.

31. Dr. Ackerman opined that it would have been safer for Respondent to refer Patient 1 to a pain specialist or to consult a pharmacist to ensure that the fentanyl dosage was accurate and safe. Despite Respondent's limited experience with fentanyl patches, Dr. Helm opined that Respondent was not required to refer Patient 1 to a pain management expert or consult with a pain management physician before switching the Norco to the fentanyl patch. Dr. Helm noted that PCPs are the largest prescribers of controlled substances in this country, and it is well within the standard of care for them to prescribe all forms of opioids. Dr. Helm's opinion in this regard was more persuasive and established that it was within the standard of care for Respondent to prescribe a fentanyl patch.

32. While it was within the standard of care for Respondent to prescribe a fentanyl patch, given her lack of extensive experience prescribing it and given the complexity of the conversion from other opioid doses to fentanyl (evidenced by her attendance at a seminar to learn how to use a conversion table) Respondent should have taken great care in determining the correct dosage and ensured its accuracy. Additionally, given Respondent's pain management training in 2004 and her subsequent seminar attendance pertaining to opioid prescribing, in 2013, she

apparently understood the dangers of opiate use and the importance of proper and careful prescribing.

33A. Dr. Akerman credibly testified that, when converting from a narcotic to a fentanyl transdermal patch, it is the standard of care to carefully select the correct dosage. Dr. Ackerman noted that Patient 1 had been taking a combination of oxycodone 30 mg four times per day as needed for pain, plus Norco 20 mg (two 10 mg tablets) every four to six hours. The recommended dose conversion from the Norco to the fentanyl transdermal patch was the 50-mcg patch. This is double the dosage that Respondent prescribed, which was the 100-mcg patch.

33B. Additionally, Dr. Ackerman opined that transdermal fentanyl should only be prescribed for patients with stable opioid requirements. He noted that, while Patient 1's analgesic regimen had not changed for several months, it was not stable on her July 1, 2013 visit (the day the fentanyl patch was started), because the patient had fallen the prior day, exacerbating her pain in the same location where she had earlier suffered a sacral fracture. (Exhibit 15, p. 8 [e-p. 537].) Dr. Ackerman opined that Patient 1 should not have been started on the fentanyl patch the day after a fall that caused increased pain, noting that fentanyl patches may initially take at least 12 hours for analgesia to take effect and at least 36 hours to achieve a maximum steady state concentration. This triggered the risk that Patient 1 may ingest additional oxycodone for acute pain while awaiting the fentanyl patch to gradually provide analgesia, ultimately risking overdose.

33C. Given the foregoing, Dr. Ackerman credibly concluded that Respondent committed an extreme departure from the standard of care in prescribing the 100-mcg fentanyl patch to Patient 1.

34A. Dr. Helm acknowledged that fentanyl is a potent analgesic, and that it is more potent than Norco or oxycodone and requires a much smaller dose than Norco to achieve the same effect. However, he asserted that there was no greater risk with fentanyl than with other opiates. Nevertheless, he admitted Respondent "got the conversion wrong."

34B. Dr. Helm opined that Respondent's misunderstanding of the conversion calculation and her prescribing of the higher dosage 100 mcg patch constituted only a simple departure from the standard of care. Dr. Helm's understanding of the difference between a simple and an extreme departure from the standard of care is that a simple departure is one that he "can understand how it happened," and an extreme departure is one that he "can't understand how it happened." Dr. Helm explained that a miscalculation of opioid conversion is "something [he] can understand how it happens" because practitioners can misinterpret or misapply the conversion tables. Dr. Helm's understanding of the difference between a simple and extreme departure from the standard of care is imprecise and flawed. Understanding how an error happens does not convert it to a simple departure. Rather, as noted above (Factual Finding 27), as the risk was increased by the danger of overdose and death from a potent opioid, the failure to exercise great caution in determining the appropriate dosage constituted an extreme departure from the standard of care.

35. As detailed above, Drs. Ackerman and Helm provided divergent views regarding how far Respondent diverged from the standard of care in prescribing the 100-mcg fentanyl patch. Both experts testified in a forthright manner and asserted their positions with equal certainty. Upon weighing their conflicting views, Dr. Ackerman's opinion was more persuasive that Dr. Helm's in establishing that Respondent committed an extreme departure from the standard of care in prescribing

the incorrect dosage of fentanyl to Patient 1 on July 1, 2013. Respondent should have exercised greater caution due to the substantial danger commensurate with prescribing such a powerful narcotic and the critical need for ensuring the correct dosage given the complex conversion required. Respondent's failure to exercise the appropriate caution and her prescribing double the recommended dosage of fentanyl was compounded by the danger of prescribing it to a patient who was taking as-needed oxycodone and was experiencing increased acute pain from a fall the day prior, thus risking her potential overuse of oxycodone while waiting for the analgesic effect of the fentanyl patch.

36. Drs. Ackerman and Helm agreed that physicians must provide proper counseling when starting a patient on a fentanyl patch, including cautioning the patient against exposing the patch application site to extreme heat sources such as heating pads, electric blankets, heated water beds, hot baths, saunas, Jacuzzis, or excessive sun exposure. Dr. Ackerman's expert report concluded that, in addition to selecting the incorrect dosage, Respondent committed an extreme departure from the standard of care by "prescribing a powerful controlled-release narcotic to a patient [for] whom inadequate counseling was provided about potential side effects and standard precautions to be taken [was] not given." (Exhibit 15, p. 11 [e-p. 539].) At hearing, Dr. Ackerman noted that Respondent did not document that she had provided the patient with these cautions. However, despite that lack of documentation, the clear and convincing evidence did not establish that Respondent failed to provide these cautions. (See Factual Finding 23(D)(2) and fn. 20.)

REPEATED NEGLIGENT ACTS / FAILURE TO MAINTAIN ADEQUATE RECORDS

37A. Complainant alleges that Respondent engaged in repeated negligent acts as follows:

> Respondent also failed to adequately document her medical decision-making regarding her use of benzodiazepines to treat Patient 1's comorbid depressive disorder, and regarding her use of opioids to treat the patient's pain. Respondent also failed to document a complete history of Patient 1's anxiety and failed to adequately document Patient 1's pain disorder, including the history of the present illness and appropriate physical examinations. There was minimal documentation of the patient's chronic pain on all visits in the history. For example, it did not include description of the pain, location, intensity, quality, onset/duration, along with variations/patterns/rhythms, exacerbators and alleviators. Previous diagnostic evaluations performed and results thereof were not documented. Moreover, Respondent failed to document the exploration of alternative non-narcotic medications and treatment, and no pain scales were documented on days of clinic visits.

(Exhibit 1, p. 9 [e-p. 10].)

37B. The alleged repeated negligence (second cause for discipline) comprises only alleged documentation omissions. As a separate (third) cause for discipline, Complainant also alleges that Respondent failed to maintain adequate and accurate records of her care and treatment of Patient 1.

38A. In his expert report, when opining that Respondent engaged in simple negligence, Dr. Ackerman states that, under the standard of care, "benzodiazepines are

not the first line therapy for treatment of anxiety." (Exhibit 15, p. 11 [e-p. 539].) However, he focused on the October 10, 2011 visit, and follow-up visits in November 2011 and January 2012, in criticizing Respondent's prescribing of benzodiazepines and opining that she engaged in simple departure from the standard of care. As those visits predate the statute of limitations cut-off of July 17, 2012 in this matter (see footnote 2), Respondent cannot be disciplined for any negligence committed on those dates.

38B. Additionally, in his expert report, Dr. Ackerman opined, "Many physicians would consider having a patient with comorbid chronic pain and affective disorders of depression and anxiety see a psychiatrist to help manage the patient. This is especially true after [Respondent] had tried multiple different benzodiazepines, or on 1/28/13 when [Respondent] diagnosed Patient 1 had 'Anxiety with Somatoform Disorder and Somatoform Pain Syndrome.'" (Exhibit 15, p. 12 [e-p. 540].) However, at the administrative hearing, Dr. Ackerman opined, and Dr. Helm agreed, that Respondent's failure to refer to Patient 1 to a psychiatrist was not below the standard of care. As noted above (in the preamble of this Decision), the allegation in the Accusation that Respondent departed from the standard of care "by failing to refer Patient 1 to a psychiatrist" was deleted.

38C. Complainant failed to establish, by clear and convincing evidence, that Respondent committed repeated negligent acts in her prescribing of benzodiazepines to Patient 1.

39A. As noted above, Complainant alleges that Respondent's documentation omissions comprise repeated acts of negligence and a failure to maintain adequate records. The alleged omissions include: (1) failure to adequately document Patient 1's pain disorder, including the history of the present illness and appropriate physical

examinations; (2) minimal documentation of the patient's chronic pain on all visits in the history (e.g., description of the pain, location, intensity, quality, onset/duration, along with variations/patterns/rhythms, exacerbators and alleviators, and pain scales); (3) failure to document diagnostic evaluations performed and results thereof; and (4) failure to document exploration of alternative non-narcotic medications.

39B. Dr. Ackerman opined that Respondent's recordkeeping departed from the standard of care and constituted a simple departure. He testified that the standard of care requires documentation of the date of the encounter, a history and physical, an assessment, a plan, and any diagnostic studies and the dates of those.

39C. Dr. Ackerman opined that, throughout the entire medical record, Respondent consistently failed to adequately document Patient 1's pain disorder. Documentation predating the statute of limitations cut-off of July 17, 2012 in this matter (see footnote 2), will not be considered in determining if Respondent committed negligence or failed to maintain adequate records on those dates.

39D. Dr. Ackerman opined that Respondent's documentation was inadequate because the reader cannot discern "what the pain is," and whether it is due to chronic back pain, lupus, fibromyalgia, falls, or constipation. He maintained that there was no documentation of "how bad" the pain was, "what makes it better or worse," and what treatments have been "tried." Dr. Ackerman specifically pointed to Respondent's January 28, 2013 chart note to demonstrate inadequate documentation of Patient 1's pain disorder. Although that note included diagnoses of Patient 1's somatoform pain syndrome and systemic lupus, Dr. Ackerman testified, "it would be nice to know exactly what the pain is or if it was [from] multiple [causes]," and also if it is chronic or if it is "new or worsening of prior chronic" pain. He also pointed to Respondent's March 28, 2013 chart note, stating that while the history was "better than other ones and does

include some more historical context, it would be nice in the assessment and plan to indicate what [she was] actually treating" with each medication.

39E. Dr. Ackerman's assertion that Respondent consistently failed to document the cause of Patient 1's pain was not borne out by the evidence. As noted above (Factual Finding 16), when Patient 1 saw Respondent on August 27, 2012, September 27, 2012, October 29, 2012, and November 26, 2012, Respondent documented Patient 1's complaints of various pain, including pain in her left knee radiating down her left leg (on 8/27/12), pain in her legs and arms (on 9/27/12), low back tenderness (on 10/29/12), and pain in her knees and lower legs (on 11/26/12). Additionally, in February 2013, Respondent documented Patient 1's pain from falling three weeks prior, and on July 1, 2013, from falling down the day before.

39F. Dr. Ackerman acknowledged that Patient 1's records appropriately included laboratory studies and radiological studies ordered by Respondent, and there was documentation that Respondent informed the patient of the results. He also acknowledged that Respondent's notes followed the SOAP format (subjective, objective, assessment and plan); that each note was individually typed and not cut and pasted from the prior visit as seen in many electronic medical records; and most of her notes documented the reason for changing medications.

40. Dr. Helm opined credibly that Respondent's recordkeeping between July 2012 and July 1, 2013 was adequate and within the standard of care for PCPs including internists. He noted that the note for every visit included a detailed history of present illness and specific documentation of a new physical examination, not the cutting and pasting typically seen in electronic medical records. He also noted that the reader could follow reasoning for the decision to provide medications, the side effects and patient's reactions to medications.

41. Upon weighing their conflicting views, Dr. Helm's opinions were more persuasive that Dr. Ackerman's regarding whether Respondent committed repeated negligent acts and failed to maintain adequate records in documenting Patient 1's pain and diagnostic evaluations.

42A. Complainant also alleged that Respondent failed to maintain adequate records by failing to document her counseling of Patient 1 about the safety concerns regarding fentanyl.

42B. (1) At the administrative hearing, the parties disagreed about the use of the Board's published "Guidelines for Prescribing Controlled Substances for Pain" (Guidelines) in determining the standard of care. The Guidelines, adopted in 1994 and revised in 2007, remained effective in 2012-2013. The Guidelines specify that they are a policy statement, drafted after research, hearings, and discussion, and "intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the [Board] so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain." (Exhibit 16, p. 1 [e-p. 543].) The Guidelines state, "California physicians and surgeons are encouraged to consult this policy statement and the guidelines below." (*Ibid.*)

(2) Dr. Ackerman testified that most physicians would use the Guidelines as the standard of care. Dr. Helm testified that the Guidelines represent best practices and that the standard of care "is lagging," behind best practices.

(3) The Board's Guidelines are not documentation of the standard of care. Indeed, the Guidelines specify, "The [Board] expects physicians and surgeons to

follow the standard of care in managing pain patients." (Exhibit 16, p. 2 [e-p. 544].) However, since the Guidelines are a statement of what is accepted practice and since reasonable practitioners would consult and follow them, they comprise part of the standard of care as practiced by reasonable physicians in California. Additionally, given that they were updated in 2007, by 2012-2013, they would have become more adapted into the standard of care as practiced by reasonable physicians in California.

42C. The Guidelines state the following:

> **Informed Consent**
>
> The physician and surgeon should discuss the risk and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.
>
> [¶] . . . [¶]
>
> **Records**
>
> The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, . . . treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications. . . .

(Exhibit 16, pp. 3, 4 [e-pp. 545, 546].)

42D. Dr. Ackerman opined credibly that the standard of care required Respondent to document her informed consent discussion. Respondent failed to document any counseling discussion with Patient 1 about fentanyl use.

42E. Dr. Helm opined that the standard of care for recordkeeping did not require that informed consent of the patient be documented when prescribing a new medication to the patient. He pointed out that the Guidelines, under the Informed Consent section, only used the word "discuss" and recommended a discussion, but they did not state that the discussion had to be documented. On cross examination, Dr. Helm was shown the Records section of the Guidelines recommending the physician keep accurate and complete records including informed consent. Dr. Helm argued that the Guidelines "are internally inconsistent" because under the Informed Consent section, they say to "discuss" but not "write" about informed consent, but under the Records section, they recommend documentation of informed consent. This argument is illogical and is not persuasive.

42F. Upon weighing their conflicting views, Dr. Ackerman's opinion was more persuasive than Dr. Helm's in establishing that Respondent failed to maintain accurate and adequate records by failing to document her informed consent discussion, including precautions about the use of the fentanyl patch.

Rehabilitation and Character References

43. Respondent earned her medical degree from UCLA in 1990. From 1993 through 2013, Respondent was certified by the American Board of Internal Medicine. In 2013, Respondent was board eligible for re-certification, but decided not to pursue recertification.

44. In 1995, Respondent joined Century Medical Group (CMG), in Van Nuys, California. Respondent is currently the Chief Executive Officer of CMG, overseeing the financial aspect of the medical group's practice. CMG currently employs four

physicians, and its Van Nuys location provides medical care to an underserved patient population.

45. Respondent has never been subject to Board discipline.

46. From 1994 through 2017, Respondent traveled to Vietnam on annual medical missions to provide healthcare to people in impoverished villages. In 2019, she participated in a medical mission to Cambodia. In 2011 and 2012, Respondent volunteered with Care Harbor providing free medical care to downtown Los Angeles patients who were homeless or lacked health insurance.

47. At the administrative hearing, Respondent expressed extreme regret for her dosing error and great sorrow about Patient 1's death.

48A. In 2014, the Board updated its guidelines for prescribing pain medications, and Respondent continued her attempts to keep abreast of changes in the medical community. She knew then that there were "drastic changes going on in the pain management field," and she completed a 15-hour course on chronic pain and opioid management.

48B. In 2014, CMG began an ongoing discussion on how best to follow the Board's 2014 guidelines. That year CMG created its "Century Medical Group Policies on Controlled Substance Prescribing," instituting new requirements including patients completing and signing a Narcotic Medication Agreement, patients undergoing regular urine drug screens, physicians or nurses reviewing an internal Prescription

Drug Monitoring Program report, and physicians reviewing the Controlled Substance Utilization Review and Evaluation System (CURES).[22]

48C. In 2014, another physician at CMG was tasked with conducting the CURES reviews. However, in 2015, Respondent registered with CURES. In 2016, she was able to regularly use CURES when the updated CURES 2.0 was released, allowing easier computer-based access for clinicians rather than requiring facsimile submission of inquiries.

48D. Respondent currently prescribes pain medications. However, if the medication does not remedy the pain or increase the patient's functioning level, Respondent will discontinue the prescription.

49. In 2017 and 2019, Respondent completed continuing medical education (CME) courses dealing with opioid safety and responsible opioid prescribing.

50A. In February 2020, after notice of the Accusation, the credentialing committee of LA Care Health Plan insurance requested that CMG's HMO, Regal Medical Group, Inc. / Lakeside Community Healthcare (Regal), conduct a pharmacy utilization patient medical record review. Regal conducted a medical chart review of 17 of Respondent's randomly selected patient records with a date range between July 2019 and March 2020. On August 14, 2020, Regal sent Respondent a letter informing her of its findings and recommendations. Specifically, Regal stated:

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[22] CURES allows healthcare prescribers, pharmacists, law enforcement, and regulatory boards to access patients' and providers'-controlled substance prescription histories.

> The review revealed your pharmacy utilization to be appropriate, with opportunities to improve medical records related to medication prescribing. As per our phone conversation of August 10, 2020, you have agreed to schedule to attend the [Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego] prescribing course. Upon completion of the course please forward the results to the [Regal] Credentialing Department as evidence of ongoing monitoring and issue closure.

(Exhibit O, p. 1 [e-p. 114].)

50B. Respondent recalled the Regal audit found many of her patients with narcotic agreements did not sign annual renewals, and she was instructed to do have them do so. Respondent modified her protocols to incorporate the annual narcotics agreement renewal into her practice. Regal also instructed her to check CURES every three to four months instead of every three to six months, and she changed her practice to comply. Respondent completed the PACE prescribing course on October 19 – 21, 2020.

51. In September 2020, Respondent registered to take the PACE Medical Record Keeping course scheduled for January 2021.

52A. Respondent has the support of her colleagues and patients who provided letters of reference and testified on her behalf. They collectively described Respondent as trustworthy, diligent, caring, devoted to patients, and an asset to the community.

52B. Stephen Reale, M.D., who has worked at with Respondent at CMG since 1996, testified at the administrative hearing and submitted a letter on Respondent's behalf. He described Respondent as a caring, conscientious, and "highly regarded" physician (exhibit L) who has a good reputation in the medical community and is a valuable part of that community.

52C. Munaf Shamji, M.D., a cardiologist for 20 years, has known Respondent since residency, and they often share patients. He testified that Respondent is considered a very good physician who "will go the extra mile for patients' wellbeing."

52D. Stanley Rossman, M.D., a hematologist and oncologist, has known Respondent more than 20 years. He described her as a good physician, and he confirmed she has a good reputation in the community.

LEGAL CONCLUSIONS

1. The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

2. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Respondent committed gross negligence in her care and treatment of Patient 1, as set forth in Factual Findings 3 through 36.

3. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish that Respondent committed repeated acts of negligence in her care and treatment of Patient 1, as set forth in Factual Findings 3 through 26 and 37 through 41.

4. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records in her care of Patient 1, by her failure to document the cautions regarding fentanyl use which she was required to provide the patient during an informed consent discussion, as set forth in Factual Findings 3 through 26 and 42.

5A. Complainant established that Respondent committed gross negligence in her prescribing of fentanyl to Patient 1, and that Respondent engaged in a failure to maintain adequate and accurate records by her failure to document the cautions regarding fentanyl use which she was required to provide the patient during an informed consent discussion. The remaining question is the nature of the discipline to be imposed against Respondent's certificate for her violations.

5B. Business and Professions Code section 2229 provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality . . . 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

. . . 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.

5C. Business and Professions Code section 2227, subdivision (a), 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, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

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

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

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

(4) Be publicly reprimanded by the division.

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

5D. The established area of concern in this case involves Respondent's one-time prescribing error, albeit a serious error, and a single instance of failure to maintain adequate and accurate records. In the seven years since commission of these errors, Respondent has undertaken to comply with the Board's updated 2014 prescribing guidelines by instituting protocols at her practice, including regularly reviewing CURES reports and requiring patients to undergo urine drug screens and to sign Narcotic Medication Agreements. Respondent has also completed a PACE prescribing course to remedy prescribing deficiencies, and she has enrolled in a medical recordkeeping course to address any recordkeeping deficiency. Given that protection of the public is the primary purpose of the Board, Respondent has demonstrated her desire to work in conjunction with the Board on its paramount goal of patient safety. There does not appear to be a need for Board monitoring of Respondent's practice by way of probation.

5E. In this case, cause for discipline exists, and the Board must acknowledge, to both the public and the medical community, that the acts and omissions of Respondent were in violation of Business and Profession Code sections 2234, subdivision (b), and 2266. However, in light of Respondent's 28-year history of licensure without prior discipline, her efforts to comply with the Board's 2014 prescribing guidelines by instituting changes in her practice, her demonstrated willingness to improve her prescribing and recordkeeping skills (by her completion of the PACE prescribing course, and registration to take the PACE recordkeeping course), and her otherwise laudable skills and dedication to her patients, a public reprimand with a required recordkeeping course will best protect the public without imposing overly harsh and punitive discipline on Respondent.

ORDER

1. Respondent is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Medical Record Keeping Course:

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

B. 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.

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C. 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.

DATE: Dec 14, 2020

Julie Cabos-Owen
Julie Cabos-Owen (Dec 14, 2020 08:23 PST)

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 17 2019
BY ANALYST

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

In the Matter of the Accusation Against: **Denise Anh-Duong Phan, M.D.** **15243 Vanowen Street, Suite 101** **Van Nuys, CA 91405** **Physician's and Surgeon's Certificate No. G 73973,** Respondent.	Case No. 800-2017-035186 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 28, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 73973 to Denise Anh-Duong Phan, 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 December 31, 2019, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. 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.

6. Section 2234 of the Code, states:

"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.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patient 1.[1] The circumstances are as follows:

Patient 1

9. Patient 1 was a fifty-five year old female who treated with Respondent on or about March 28, 2011 through July 1, 2013.[2] Patient 1 was also being treated by multiple other medical specialists/consultants, and was taking various other medications during this time period. Per the autopsy report, Patient 1 died on July 4, 2013, from acute Fentanyl and Oxycodone toxicity.

10. During the first visit on March 28, 2011, Respondent saw Patient 1, who had various maladies, including Lupus, Fibromyalgia, Hypokalemia, Depression/Anxiety, Hepatitis, and pain. During this first visit, Respondent requested prior labs and records, and referred Patient 1 to a cardiologist and gastroenterologist. Respondent also prescribed to Patient 1 Norco 10/325 mg (a.k.a. as Hydrocodone), apparently for Patient 1's Fibromyalgia.[3]

11. During the second visit on June 9, 2011, Respondent refilled the Norco prescription for Patient 1, and added Valium for the patient. Per the record, Respondent also intended to recheck Patient 1 in two weeks.[4] On or about August 2011, Patient 1 also experienced a fall and was hospitalized. Thereafter, Patient 1 had complaints of severe back pain and anxiety. Records show that Respondent prescribed to Patient 1 Ambien (a sleep aid), Ativan (for anxiety), and refilled the patient's Norco (for pain).

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[1] The patient is identified by number to protect her privacy.
[2] These dates are based on the records which were available for review.
[3] It is not the standard of care to use narcotics for the initial treatment of Fibromyalgia.
[4] Dispensing #60 tablets of Norco by Respondent to Patient 1 on June 9, 2011 was a large amount, considering that the follow-up visit was intended to be only two weeks away. Moreover, per the records, on June 23, 2011, Respondent documented that Patient 1 was not taking the Norco during the past two weeks because she was trying to save the medications.

12. On or about November 9, 2011, Anthem Blue Cross Insurance Company wrote to Respondent alerting her that Patient 1 had been filling a large number of controlled substances by multiple providers within three months. Over that three-month period, Patient 1 was on opiates like Hydromorphone, Hydrocodone, and two different Benzodiazepines (Lorazepam and Temazepam) as well as Zolpidem (Ambien).[5]

13. On the last visit, July 1, 2013, Respondent changed Patient 1's analgesic and prescribed to Patient 1 a 100 mcg patch of Fentanyl, after being informed that Patient 1 had experienced a fall the previous day.[6] Respondent did not refer Patient 1 to a chronic pain specialist, and there appeared to be no change in Patient 1's PRN Oxycodone usage. Moreover, there appeared to be no documentation that Respondent had counselled Patient 1 about the safety concerns and potential side effects from Fentanyl.

14. These acts or omissions in the treatment of Patient 1, as described above, represents an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in her care of Patient 1 above. The circumstances are as follows:

16. The facts and circumstances in paragraphs 9 through 14, above, are incorporated by reference as if set forth in full herein.

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[5] Despite being alerted that Patient 1 was being prescribed multiple controlled substances by multiple providers and was filling the medications at different pharmacies, Respondent did not review the CURES database, and she indicated on the Anthem letter that the drug regimen was appropriate for Patient 1. In fact, records show that Respondent continued to refill/prescribe to Patient 1 multiple controlled substances (both opiates and benzodiazepines) to Patient 1, who was already on benzodiazepines, for almost two years after Respondent was alerted by Anthem. Of note, apparently Patient 1 had built up a tolerance for Norco (Hydrocodone) as early as January 17, 2012. However, instead of trying to wean the patient off the opioid, Respondent prescribed to Patient 1 another opioid (MS Contin or Oxycodone) to replace the Norco.

[6] Prescribing a Fentanyl patch should only be used in patients with stable opioid requirements. While Patient 1's analgesic regimen had not changed for several months, one could argue that her pain was not in a stable condition, and that the pain was likely exacerbated by her fall the previous day. Moreover, the dosing schedule used by Respondent in converting Patient 1 to the Fentanyl patch was too high.

17. Respondent also committed repeated negligent acts in her care of Patient 1 above. The circumstances are as follows:

Patient 1

18. Respondent departed from the standard of care by not adequately treating Patient 1's comorbid pain and affective disorders of depression and anxiety with benzodiazepines, and by failing to refer Patient 1 to a psychiatrist.

19. Respondent also failed to adequately document her medical decision-making regarding her use of benzodiazepines to treat Patient 1's comorbid depressive disorder, and regarding her use of opioids to treat the patient's pain. Respondent also failed to document a complete history of Patient 1's anxiety, and failed to adequately document Patient 1's pain disorder, including the history of the present illness and appropriate physical examinations. There was minimal documentation of the patient's chronic pain on all visits in the history. It did not include description of the pain, location, intensity, quality, onset/duration, along with variations/patterns/rhythms, exacerbators and alleviators. Previous diagnostic evaluations performed and results thereof were not documented. Moreover, Respondent failed to document the exploration of alternative non-narcotic medications and treatment, and no pain scales were documented on days of clinic visits.

20. These acts or omissions in the treatment of Patient 1, as described above, represent simple departures from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Records)

21. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of her care and treatment of Patient 1.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 73973, issued to Denise Anh-Duong Phan, M.D.;

2. Revoking, suspending or denying approval of Denise Anh-Duong Phan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Denise Anh-Duong Phan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: June 17, 2019

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