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

In the Matter of the First Amended Accusation Against:	
David Brooks, M.D.	**Case No. 800-2019-053391**
Physician's and Surgeon's Certificate No. G 11503	
Respondent.	

DECISION

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

This Decision shall become effective at 5:00 p.m. on September 1, 2022.

IT IS SO ORDERED August 25, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka, Executive Director
Medical Board of California

ROB BONTA
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **DAVID BROOKS, M.D.** **176 S. Palm Street** **Blythe, CA 92225** **Physician's and Surgeon's Certificate No. G 11503,** Respondent.	Case No. 800-2019-053391 OAH No. 2021110596 **STIPULATED SURRENDER OF LICENSE 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. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Karolyn M. Westfall, Deputy Attorney General.

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2. David Brooks, M.D. (Respondent) is represented in this proceeding by attorneys Peter R. Osinoff, Esq., and Carolyn Lindholm, Esq., whose address is: Bonne Bridges, Mueller, O'Keefe & Nichols, 355 South Grand Avenue, Suite 1750, Los Angeles, CA 90071-1562.

3. On or about December 13, 1965, the Board issued Physician's' and Surgeon's Certificate No. G 11503 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-053391 and will expire on October 31, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2019-053391, which superseded the Accusation filed on October 12, 2021, was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on March 3, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2019-053391 is attached hereto as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2019-053391. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2019-053391, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 11503 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G 11503 for the Board's formal acceptance with an agreed upon effective date of September 1, 2022.

9. Respondent agrees that his Physician's and Surgeon's Certificate No. G 11503 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 11503, all of the charges and allegations contained in First Amended Accusation No. 800-2019-053391 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 11503 without further process.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. This stipulation shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By

signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Board, considers and acts upon it.

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 11503, issued to Respondent David Brooks, M.D., is surrendered effective September 1, 2022, and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order, which shall be September 1, 2022.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2019-053391 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

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5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $3,491.25 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation, No. 800-2019-053391 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorneys Peter R. Osinoff, Esq., and/or Carolyn Lindholm, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 05-19-2022

DAVID BROOKS, M.D.
Respondent

I have read and fully discussed with Respondent David Brooks, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 5/19/22

PETER R. OSINOFF, ESQ.
CAROLYN LINDHOLM, ESQ.
Attorneys for Respondent

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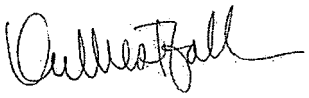
ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 5/19/22

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-053391

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **DAVID BROOKS, M.D.** **176 S. Palm Street** **Blythe, CA 92225** **Physician's and Surgeon's Certificate No. G 11503,** Respondent.	Case No. 800-2019-053391 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 13, 1965, the Board issued Physician's and Surgeon's Certificate No. G 11503 to David Brooks, 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 October 31, 2023 unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on October 12, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

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

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

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6. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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.

COST RECOVERY

8. Section 125.3 of the Code states:

> (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
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> (b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.
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> (c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.
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> (d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).
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> (e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.
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> (f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

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(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 11503 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A and B,[1] as more particularly alleged hereinafter:

10. Since in or around 1992, Respondent has maintained a solo general medicine practice out of his home in Blythe, California.

11. On or about November 15, 2019, Board investigators performed an unannounced site inspection at Respondent's clinic. During this inspection, investigators witnessed expired medications stored immediately beside food inside the kitchen refrigerator, hundreds of bottles of expired medications belonging to deceased patients located in bags and on shelves in a storage room, medication and medical equipment maintained in unsanitary conditions, and patient medical records stored in milk crates on shelves in a room between the reception area and the kitchen. At that time, Respondent admitted to investigators that he sometimes provides the

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[1] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

expired medications to patients who cannot afford medical treatment, but informed the investigators that he would dispose of the medications properly.

12. On or about December 16, 2019, Board investigators returned to Respondent's clinic for another unannounced site visit and noted Respondent had still not disposed of the hundreds of bottles of expired medications. Respondent authorized the investigators to dispose of the medications for him, which filled approximately sixteen large garbage bags.

PATIENT A

13. On or about April 5, 2019, Respondent began providing primary care treatment to Patient A, a then fifty-two year old female patient. At this initial visit, and every visit thereafter, Respondent obtained the patient's vital signs and took short illegible notes that did not include a physical examination or review of systems. At the conclusion of this visit, Respondent did not specify a diagnosis for Patient A,[2] but prescribed her multiple medications including 90 tablets of methadone[3] 10mg, and 30 tablets of lorazepam[4] 2mg.[5]

14. Between on or about April 5, 2019, and on or about February 28, 2020, Patient A presented to Respondent for approximately twelve (12) clinical visits. Throughout that time, Respondent did not obtain a detailed history from the patient, did not perform a focused physical examination, did not elicit information from the patient regarding the cause, location, duration, or nature of her pain, did not obtain any prior imaging or other treatment records, did not recommend non-pharmacologic treatment modalities, did not offer or recommend safer alternatives to opioids and benzodiazepines, did not did document a discussion with the patient

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[2] At the subject interview on February 23, 2021, Respondent stated he was treating the a patient for pain.

[3] Methadone is an opioid medication used for the treatment of pain or drug addiction. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Lorazepam (brand name Ativan) is a benzodiazepine medication used to treat anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] The number and dosing of the prescribed medications was not identified in the patient's chart at each visit. This information was obtained from CURES and original prescriptions.

regarding the risks and benefits of the use of opioids and benzodiazepines, did not obtain a baseline EKG, did not refer the patient to any specialists, did not assess the patient for drug addiction or aberrancy, did not perform a psychological evaluation, did not complete an anxiety screening questionnaire, and did not review CURES.[6]

15. On or about May 3, 2019, Patient A presented to Respondent for a follow-up visit. During this visit, Respondent obtained the patient's vital signs and prescribed the patient multiple medications including 90 tablets of methadone 10mg, 30 tablets of lorazepam 2mg, and 120 tablets of tramadol[7] 50mg.

16. Between on or about May 3, 2019, and on or about October 25, 2019, Patient A presented to Respondent for approximately seven (7) clinical visits. Throughout that time, Respondent maintained the patient on her medication regimen of methadone, lorazepam, and tramadol.

17. On or about May 17, 2019, Patient A provided a urinalysis at Palo Verde Hospital that revealed negative results for benzodiazepines and opiates, and positive results for cannabinoids. Respondent did not discuss these results with the patient at her subsequent visit, or any visit thereafter.

18. On or about November 29, 2019, Patient A presented to Respondent for a follow-up visit with complaints of a resistant urinary tract infection. During this visit, Respondent obtained the patient's vital signs and prescribed her multiple medications including 90 tablets of methadone 10mg, 120 tablets of tramadol 50mg, and 30 tablets of clonazepam[8] 2mg.

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[6] The Controlled Substances Utilization Review and Evaluation System (CURES), is a database maintained by the Department of Justice of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

[7] Tramadol (brand name Ultram) is an opioid analgesic medication. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Clonazepam (brand name Klonopin) is a benzodiazepine medication used to treat anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Between on or about November 29, 2019, and on or about February 28, 2020, Patient A presented to Respondent for approximately five (5) clinical visits. Throughout that time, Respondent maintained the patient on her medication regimen of methadone, clonazepam, and tramadol.

20. Between on or about May 3, 2019, and on or about February 28, 2020, Respondent maintained Patient A on a high narcotic dosage without performing or documenting a functional assessment of the patient with a focus on analgesia, activities of daily living, adverse effects of opiates, aberrant behaviors, or the patient's affect. Respondent did not have the patient sign a pain management agreement, did not document a review of CURES, did not order any urine screens to assess for aberrancy, and did not perform any pill counts. Respondent did not identify any treatment goals, did not attempt to taper the patient's medications, and did not prescribe naloxone.

21. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

A. Failing to appropriately evaluate and manage the patient's chronic pain;

B. Failing to risk stratify the patient prior to initiating opiate therapy, and then failing to properly monitor the patient's use of opiate pain medications, while continuing to prescribe chronic opiate therapy; and

C. Failing to maintain and securely store adequate and accurate records.

PATIENT B

22. On or about March 21, 2017, Respondent began providing primary care treatment to Patient B, a then fifty-five year old female patient with a history of human immunodeficiency virus and diabetes. At this initial visit, and every visit thereafter, Respondent obtained the patient's vital signs, and took short illegible notes that did not include a physical examination or review of systems. At this visit Respondent did not specify a diagnosis for Patient B or a plan for treatment, other than to state, "refills," without mention of a type or dose of any specific

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medication.[9] Although it is not documented in the chart, at the conclusion of this visit, Respondent prescribed the patient 60 tablets of Norco[10] 10/325 mg.[11]

23. On or about April 20, 2017, Patient B presented to Respondent for a follow-up visit. During this visit, Respondent obtained the patient's vital signs and glucose value, but did not document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion of this visit, Respondent prescribed the patient 90 tablets of Norco 10/325 mg and 30 tablets of diazepam[12] 10mg.

24. Between on or about April 20, 2017, and on or about September 30, 2019, Patient B presented to Respondent for approximately sixteen (16) clinical visits. Throughout that time, Respondent did not obtain a detailed history from Patient B, did not perform a focused physical examination, did not elicit information from the patient regarding the cause, location, duration, or nature of her pain, did not elicit information about the nature or frequency of her insomnia, did not obtain any prior imaging or other treatment records, did not recommend non-pharmacologic treatment modalities, did not offer or recommend safer alternatives to opioids and benzodiazepines, did not document a discussion with the patient regarding the risks and benefits of the use of opioids and benzodiazepines, did not refer the patient to any specialists, did not assess the patient for drug addiction or aberrancy, did not perform a psychological evaluation, did not complete an anxiety screening questionnaire, did not review CURES, did not provide dietary counselling or education, did not obtain regular Hgb A1C checks, did not obtain cholesterol blood

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[9] At the subject interview on February 23, 2021, Respondent stated he was treating the patient for back pain and insomnia.

[10] Norco (brand name for hydrocodone and acetaminophen) is an opioid combination medication used for the treatment of pain. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[11] The number and dosing of the prescribed medications was not identified in the patient's chart at each visit. This information was obtained from CURES and original prescriptions.

[12] Diazepam (brand name Valium) is a benzodiazepine medication used to treat anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

testing, did not prescribe cholesterol medication, and did not perform an eye screening or foot sensory examination.

25. On or about January 24, 2018, Patient B presented to Respondent for a follow-up visit. During this visit, Respondent obtained the patient's vital signs and glucose value, but did not document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion of this visit, Respondent prescribed the patient 30 tablets of diazepam 10mg and 90 tablets of oxycodone[13] 30mg.

26. Between on or about January 24, 2018, and on or about April 29, 2019, Patient B presented to Respondent for approximately twelve (12) clinical visits. Throughout that time, Respondent maintained the patient on her medication regimen of oxycodone and diazepam.

27. On or about June 26, 2019, Patient B presented to Respondent for a follow-up visit. During this visit, Respondent obtained the patient's vital signs and glucose value, but did not document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion of this visit, Respondent prescribed the patient 90 tabs of oxycodone 30mg and an unknown amount of gabapentin.[14]

28. On or about June 30, 2019, Respondent received a notification from Silver Script alerting him that Patient B was receiving a potentially dangerous combination of gabapentin and oxycodone.

29. Between on or about June 26, 2019, and on or about September 30, 2019, Patient B presented to Respondent for approximately four (4) clinical visits. Throughout that time, Respondent maintained the patient on her medication regimen of oxycodone and gabapentin.

30. Between on or about January 24, 2018, and on or about September 30, 2019, Respondent maintained Patient B on a high narcotic dosage without performing or documenting a functional assessment of the patient with a focus on analgesia, activities of daily living, adverse

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[13] Oxycodone (brand name Oxycontin) is an opioid medication used for the treatment of pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Gabapentin is an anticonvulsant and nerve pain medication, and a dangerous drug pursuant to Business and Professions Code section 4022.

effects of opiates, aberrant behaviors, or the patient's affect. Respondent did not have the patient sign a pain management agreement, did not document a review of CURES, did not order any urine screens to assess for aberrancy, and did not perform any pill counts. Respondent did not identify any treatment goals, did not attempt to taper the patient's medications, and did not prescribe naloxone.

31. Respondent committed gross negligence in his care and treatment of Patient B, which included, but was not limited to, the following:

A. Failing to appropriately evaluate and manage the patient's chronic pain;

B. Failing to risk stratify the patient prior to initiating opiate therapy, and then failing to properly monitor the patient's use of opiate pain medications, while continuing to prescribe chronic opiate therapy;

C. Failing to appropriately manage the patient's diabetic care, including but not limited to, failing to provide dietary counseling or education, failing to obtain regular Hgb A1C check every 3-6 months, and failing to obtain eye screening or feet sensory exams; and

D. Failing to maintain and securely store adequate and accurate records.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 11503 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A and B, as more particularly alleged hereinafter:

A. Paragraphs 9 through 31(D), above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Prescribing Patient A lorazepam without indication, without an appropriate evaluation, and without considering and recommending non-benzodiazepine treatment;

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C. Prescribing Patient A an unsafe combination of opiate and benzodiazepine medications without making attempts to taper and without prescribing naloxone;

D. Prescribing methadone to Patient A without a documented assessment or indication;

E. Prescribing Valium to Patient B without indication, without an appropriate evaluation, and without considering and recommending non-benzodiazepine treatment; and

F. Prescribing Patient B an unsafe combination of opiate and benzodiazepine medications without making attempts to taper and without prescribing the patient naloxone.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

33. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 11503 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients A and B, as more particularly alleged in paragraphs 9 through 31(D), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

34. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 11503 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 33, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 No. G 11503, issued to Respondent, David Brooks, M.D.;

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

3. Ordering Respondent, David Brooks, M.D., to pay the Board the costs of the investigation and enforcement of this case, and 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: MAR 0 3 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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