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

In the Matter of the Accusation Against: Karim Toursarkissian, M.D. Physician's and Surgeon's Certificate No. G 87408 Respondent.	Case No.: 800-2019-061126

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 10, 2022.

IT IS SO ORDERED: October 13, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KARIM TOURSARKISSIAN, M.D.** **5957 West Ramsey Street** **Banning, California 92220-3058** **Physician's and Surgeon's Certificate No. G 87408,** Respondent.	Case No. 800-2019-061126 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. 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 Rebecca L. Smith, Deputy Attorney General.

2. Karim Toursarkissian, M.D. (Respondent) is represented in this proceeding by attorney Campbell H. Finlay, whose address is 3105 Sedona Court, Ontario, California 91764.

3. On or about January 12, 2005, the Board issued Physician's and Surgeon's Certificate No. G 87408 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-061126, and will expire on January 31, 2023, unless

renewed.

JURISDICTION

4. Accusation No. 800-2019-061126 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 31, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-061126 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-061126. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-061126, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2019-061126, 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 87408 to disciplinary action.

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

CONTINGENCY

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

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-061126 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.

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

16. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile

signatures thereto, shall have the same force and effect as the originals.

17. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 87408 issued to Respondent Karim Tousarkissian, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall

provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the program or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

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

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

the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within sixty (60) calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program

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

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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

9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $14,270.00 (fourteen thousand two hundred seventy dollars and no cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

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

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

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

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

Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

18. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-061126 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 license.

ACCEPTANCE

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

DATED: 07/15/2022

KARIM TOURSARKISSIAN, M.D.
Respondent

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

DATED: July 15, 2022

CAMPBELL H. FINLAY
Attorney for Respondent

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ENDORSEMENT

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

DATED: July 15, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-061126

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against: **KARIM TOURSARKISSIAN, M.D.** **5957 West Ramsey Street** **Banning, CA 92220** **Physician's and Surgeon's Certificate No. G 87408,** Respondent.	Case No. 800-2019-061126 **ACCUSATION**

PARTIES

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

2. On January 12, 2005, the Board issued Physician's and Surgeon's Certificate Number G 87408 to Karim Toursarkissian, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2023, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (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 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. Section 2227 of the Code states:

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

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

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

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

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

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

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

7. 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 that would have warranted the denial of a certificate.

(g) The 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.

8. 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.

9. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

10. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no

longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

11. Section 725 of the Code states:

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

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

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

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

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

12. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

13. Section 4022 of the Code provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

DRUG DEFINITIONS

14. As used herein, the terms below will have the following meanings:

"Acetaminophen" is a widely used over-the-counter analgesic (pain reliever) and antipyretic (fever reducer). It is also known as paracetamol, or APAP. It is typically used for mild to moderate pain relief, such as relief of headaches. It is a major ingredient in numerous cold and flu remedies. In combination with opioid analgesics, paracetamol can also be used in the management of more severe pain such as post-surgical pain and providing palliative care in advanced cancer patients. Acute overdoses of paracetamol can cause potentially fatal liver damage and, in rare individuals, a normal dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including under the brand name Tylenol.

"Acetaminophen and codeine," also known by the brand names Tylenol with Codeine No. 3 and Tylenol with Codeine No. 4, is an opioid pain reliever. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(2).

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestions of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under various brand names including, Intensol, Xanax, and Xanax XR. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amitiza" is a brand name for lubiprostone, a drug used to treat chronic constipation, or constipation caused by opioid (narcotic) pain medicine. It is dangerous drug as defined in Code section 4022.

"Aripiprazole", is an antipsychotic medicine. It is sold under the brand name Abilify. It is a dangerous drug pursuant to Business and Professions Code section 4022.

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"Brexpiprazole" is an antipsychotic medicine approved by the FDA for use as an adjunctive therapy to antidepressants for the treatment of major depressive disorder and treatment of schizophrenia. Rexulti has a Black Box warning for increased mortality in elderly patients with dementia-related psychosis; and suicidal thoughts and behaviors. It is sold under the brand name Rexulti. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Duloxetine" is an antidepressant and nerve pain medication used to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain. Cymbalta is also used to treat a chronic pain disorder called fibromyalgia, treat pain caused by nerve damage in people with diabetes (diabetic neuropathy) and to treat chronic musculoskeletal pain, including discomfort from osteoarthritis and chronic lower back pain. It is from a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SNRI). It is sold under the brand name Cymbalta. It is a dangerous drug as defined in Code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold under the brand name Neurontin, among others. It can have potentially harmful effects when combined with opioids. It is a dangerous drug as defined in Code section 4022.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more potent than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin, Hycodan (or generically Hydromet), Lorcet, Lortab, Norco, and Hydrokon, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Oxcarbazepine," also known by the brand name Trileptal, is an anticonvulsant that is used to treat seizures and it is also sometimes used as a mood stabilizer. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Oxycodone" is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand name,

including OxyContin (a time-release formula) and Roxicodone. Oxycodone is also available in combination with other drugs and sold under brand names including, acetaminophen (Endocet, Percocet, Roxicet, and Tylox among others); aspirin (Endodan, Percodan, and Roxiprin among others); and ibuprofen (Combunox). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Code section 4022.

"Quetiapine" is an atypical antipsychotic drug used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. It is sold under the brand name Seroquel. It is a dangerous drug pursuant to Code section 4022.

"Sertraline" is a medication used to treat depression and panic attacks. It belongs to the selective serotonin reuptake inhibitors (SSRIs) group of medications. It is sold under the brand name Zoloft, among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Tapentadol" is an opioid pain medication used to help relieve moderate to severe short-term pain. It is sold under the brand name Nucynta. It is a Schedule II Controlled Substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Toradol" is a non-steroidal anti-inflammatory drug (NSAID) and is commonly used to decrease swelling, inflammation, fever, and pain. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. Tramadol is sold under various brand names, including Ultram and ConZip. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"Trazodone" is an antidepressant medication. It is used to treat major depressive disorder, anxiety disorders, and in addition to other treatment, alcohol dependence. It belongs to the serotonin receptor antagonist and reuptake inhibitors (SARIs) group of medications. It is a dangerous drug as defined in Code section 4022.

COST RECOVERY

15. 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(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.

(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).

(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.

(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.

(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.

FACTUAL SUMMARY

Patient 1:[1]

16. On May 29, 2014, Patient 1, a then 26-year-old female, was first seen by Respondent, an obstetrician and gynecologist at Beaver Medical Group, for prenatal care. She was gravida 2, para 1 at 9 weeks, 3 days gestation and had transferred her care from Kaiser Permanente Medical Group. Her prenatal course was essentially benign, except for presyncopal syndrome with associated tachycardia. She was diagnosed with postural orthostatic tachycardia syndrome

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[1] The patients herein are referred to by numbers, i.e., Patients 1 through 5 to address privacy.

(POTS),[2] which responded well to medication. On December 29, 2014, Respondent performed a repeat cesarean delivery on Patient 1.

17. On January 5, 2015, Patient 1 called Respondent's office with complaints of left lower quadrant pain when urinating. Respondent was not available and Patient 1 was advised to go to the Beaver Medical Group's Urgent Care Center (UCC).

18. On January 19, 2015, Patient 1 presented to Respondent for a post-operative visit. Respondent noted that the patient had gone to the UCC and was then sent to the emergency department where she was told that she had a seroma. She had been prescribed antibiotics and discharged home. Respondent noted that the patient was "doing well without any residual of seroma, if it ever existed." Patient 1 was advised to expect postpartum spotting for up to eight weeks and to return for a pap smear.

19. On January 22, 2015, Patient 1 called Respondent's office with a complaint of left lower quadrant pain. She was advised to return to Respondent's office for a trigger point injection. She presented to Respondent on January 28, 2015, for the trigger point injection for her left lower quadrant pain. At that time, Respondent prescribed to Patient 1 30 tablets of Norco to be taken every six hours, as needed for pain. The medical record reflects that Patient 1 denied a history of drug use. There was no documentation in Respondent's chart of any discussion of the risks of opioid use. Patient 1 was instructed to return in one week.

20. Patient 1 returned to see Respondent on February 2, 2015, at which time, she complained of pain at the site of her cesarean section scar. Respondent noted that the scar was tender upon examination. The patient was given a lidocaine injection in the area of her cesarean section scar to desensitize it. Following the injection, Patient 1 stated she felt better. She was instructed to return in one week.

21. On February 5, 2015, Patient 1 was seen at the UCC for complaints of left lower quadrant abdominal pain for the past five days as well as intermittent "sharp" pain and bladder pain following her cesarean section on December 29, 2014. Upon examination, Patient 1 was

[2] POTS is a condition that affects blood flow and causes symptoms such as lightheadedness, fainting, and a rapid increase in heartbeat, when standing up from a reclining position.

tender in the left pelvic area without rebound or guarding. She was assessed as having a possible infection status post cesarean section. She was instructed to go directly to San Gorgonio Hospital for further testing.

22. Patient 1 called Respondent's office on February 5, 2015, stating that her incision pain was still very painful and that she had been told that surgery may be necessary if the pain persisted. That same day, Respondent prescribed 40 tablets of Norco to Patient 1. Respondent did not document any discussion with the patient regarding the risk of opioid use. On February 8, 2015, Respondent noted that Patient 1 was being scheduled for an excision of subcutaneous neuroma or release of entrapped cutaneous nerve.

23. On February 12, 2015, Patient 1 was seen by Respondent. He prescribed 30 tablets of Norco (to be taken every six hours as needed for pain) to Patient 1. While Respondent noted that Patient 1 denied a history of drug use, there was no documentation in his chart of any discussion of a long-term treatment plan, including a discussion of the risks of opioid use and other co-morbid conditions.

24. On March 2, 2015, Respondent performed a scar revision surgery on an outpatient basis at Inland Surgery Center. Respondent noted that Patient 1 had developed acute post-operative cutaneous neuralgia following her repeat cesarean delivery on December 29, 2014. During the scar revision surgery, subcutaneous tissue was removed, including a white fibrous band that was suggestive of a possible nerve entrapment that resulted in a small neuroma. The patient was noted to have tolerated the procedure well. That same day, Respondent prescribed 30 tablets of Percocet to Patient 1 for post-operative pain. There was no documentation of any discussion of the risks associated with opioid use with Patient 1 in Respondent's chart.

25. On March 3, 2015, Patient 1 filled a prescription for 30 tablets of Norco prescribed by Respondent. On March 6, 2015, Respondent prescribed another 40 tablets of Norco (to be taken every six hours as needed for pain) to Patient 1. These prescriptions were issued to Patient 1 without any discussion of the risks associated with opioid use with Respondent and/or any documentation thereof.

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26. Respondent saw Patient 1 again on March 9, 2015, at which time she complained of pain in the anterior thigh on the left with an intense burning sensation. She stated that the pain was different from the incisional pain and unrelated to surgery. Respondent noted that the abdominal incision had healed. Respondent instructed the patient to have a STAT consult with pain management for the femoral nerve pain.

27. On March 16, 2015, Respondent saw Patient 1 at a follow-up visit. At that time, Patient 1 had acute pharyngitis. Respondent noted that the abdominal incision had healed and the femoral nerve pain was resolving. He ordered Tamiflu for the pharyngitis and instructed the patient to return in a week.

28. On May 13, 2015, Respondent saw Patient 1 and noted that the incision had completely healed and that her left thigh pain had completely resolved. He instructed Patient 1 to return for her pap smear and annual examination.

29. On August 14, 2015, Patient 1 left a message for Respondent notifying him that she noticed a bulge above her incision scar after coughing. Her primary care physician ordered a CT scan and referred her to a general surgeon. On August 20, 2015, Respondent noted that the patient might have had a small hernia.

30. On September 15, 2015, Patient 1 underwent an open ventral incisional hernia repair by Dr. D.S. at Loma Linda University Medical Center. Post-operatively, she developed a hematoma at the wound site. Her pain was noted to have been controlled with Norco.

31. On May 3, 2017, Patient 1 presented to Respondent for prenatal care. On October 18, 2017, Respondent performed a repeat cesarean section, hernia repair, and a left paratubal cyst removal with the placement of a Jackson-Pratt drain.[3]

32. On October 24, 2017, Patient 1 called Respondent's office requesting a Percocet refill. She stated that Dr. D.G. gave her a prescription for 5 milligrams of Percocet instead of 10 milligrams when she was discharged and that it was an inadequate dose. Despite the patient receiving a prescription for Percocet, Respondent prescribed 30 tablets of Tylenol with codeine No. 4 and 30 tablets of tramadol that same day. He did not document any discussion with the

[3] A Jackson Pratt drain is used to help drain excess fluid from the body after surgery.

patient about the potential danger and risk of overdose and/or death when taking multiple opioids.

33. On October 25, 2017, Patient 1 presented to Respondent for follow-up. She was noted to have had an allergic reaction to tramadol. Her Jackson Pratt drain was noted to still be draining 5 to 20 milligrams of serosanguinous fluid each day. Respondent prescribed to Patient 1, 40 tablets of Percocet, 60 capsules of Gabapentin, and an antibiotic, Keflex. Respondent did not document any discussion with Patient 1 in his chart, of a long-term treatment plan, the long-term effects of opioids for pain relief, and the dangers of using gabapentin in combination with opioids.

34. On October 31, 2017, Patient 1 left a message for Respondent requesting that her dose of gabapentin be increased from 100 mg to 300 mg because the 100 mg was not helping. She also requested a refill of pain medicine.

35. Patient 1 returned to see Respondent on November 1, 2017 for a post-operative follow-up visit. Respondent noted that the patient's abdomen was healing and he removed the drain. He prescribed 40 tablets of Percocet to the patient and increased the patient's dose of gabapentin to 200 milligrams. He instructed the patient to return in 2 weeks. By November 1, 2017, Respondent had prescribed opioids to Patient 1 on ten occasions without any pain management agreement in place or documentation of a long-term treatment plan or discussions regarding the risks of potential overdose or addiction. In addition, he increased the patient's gabapentin dosage without discussing its risks when used in combination with opioids with the patient or documenting the same.

36. On November 6, 2017, Patient 1 called Respondent requesting a refill of her pain medication and gabapentin prescriptions. She stated that she was still having daily low grade fevers, her incision site remained swollen, and she was having difficulty urinating. Respondent instructed the patient to go to the emergency department. She presented to the emergency department that same day. A CT scan revealed a seroma at the surgical site and she was also diagnosed with a urinary tract infection. She was prescribed an antibiotic, Bactrim DS, and was discharged in stable condition.

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37. On November 7, 2017, Patient 1 filled a prescription for 40 tablets of Percocet prescribed by Respondent. At the time of this pain medication refill, there was no documentation in the patient's chart of any discussion of a long-term treatment plan, nor was there documentation of any discussion of the long-term effects of opioids for pain relief.

38. On November 9, 2017, Patient 1 presented to Respondent for follow-up after the emergency room visit. She complained about post-operative abdominal pain. Respondent noted that the pain was appropriate given the surgery performed. She was instructed to return in two weeks.

39. On November 13, 2017, Patient 1 left a message for Respondent requesting a Percocet refill. Respondent was made aware of the request. He ordered an ultrasound of the abdominal wall. Patient 1 called again On November 15, 2017, requesting to speak with Respondent regarding pain and swelling in her abdomen and left labia. She was advised to go to the UCC, emergency department or her primary care physician, as Respondent was out of the office.

40. On November 17, 2017, Patient 1 presented to Respondent with complaints of left lower quadrant pain radiating medially into her thigh and discomfort with her umbilical hernia. Respondent noted that the patient was concerned about her Percocet use and requested non-addictive analgesics. Respondent's impression was post-operative abdominal pain. He also noted possible nerve entrapment and that a superficial cutaneous hypogastric nerve block should be considered if the pain persisted. Respondent again noted that the patient declined Percocet and requested Nucynta. Respondent prescribed 60 tablets of Nucynta (100 mg) and 90 tablets of gabapentin (300 mg). Respondent did not document any discussions with the patient regarding the risks associated with using Nucynta, nor did he document any discussions regarding the dangers and risks of using Nucynta with gabapentin.

41. On November 20, 2017, Patient 1 had an acute visit for pelvic, abdominal, and nerve pain with nurse practitioner D.K. The patient stated that she stopped taking Nucynta secondary to adverse effects. Patient 1 was prescribed Percocet and referred to neurology. She was instructed to keep her upcoming abdominal ultrasound appointment and to follow-up with Respondent.

42. On November 21, 2017, Patient 1 underwent an abdominal ultrasound. It showed no definite recurrent hernia over the left lower quadrant abdominal wall.

43. Patient 1 returned to see Respondent On November 29, 2017. She complained of severe constipation due to pain medications. Respondent noted that the patient been off Percocet for four days. He prescribed Amitiza to help with the constipation.

44. On December 12, 2017, Patient 1's spouse left a message for Respondent stating that Patient 1 was taking gabapentin and was depressed. He requested a medication change. In a follow-up call, Respondent [stated that the patient may be experiencing postpartum depression rather than a medication side effect. Respondent referred the patient to behavioral medicine to be seen as soon as possible.

45. On December 13, 2017, Respondent discontinued Patient 1's gabapentin and instructed her to start Zoloft. On December 19, 2017, the patient called Respondent to let him know that she was being treated by a psychiatrist at Loma Linda University Medical Center for postpartum depression.

46. On January 23, 2018, Patient 1 was seen in follow-up by Respondent for complaints of nerve pain. She reported that she was receiving therapy for postpartum depression and had been prescribed Cymbalta, Trileptal, trazodone, Seroquel, and Abilify. Respondent documented that the patient had postpartum depression and myofascial pain syndrome. He prescribed gabapentin for myofascial pain syndrome. Respondent did not refer Patient 1 to a pain management specialist despite being aware of the patient's ongoing treatment for psychiatric issues.

47. Patient 1 was next seen by Respondent on February 28, 2018. Her pain and postpartum depression were discussed with Respondent. He noted that the patient had a mostly flat affect, was unkempt, anxious, easily distracted, and had poor concentration. Respondent's impression was postpartum depression and myofascial pain syndrome. Respondent prescribed 120 tablets of gabapentin to the patient. Respondent did not refer Patient 1 to a pain management specialist despite being aware of the patient's ongoing treatment for depression.

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48. On March 26, 2018, Respondent underwent a bilateral tubal ligation performed by Respondent at Inland Surgery Center. That same day, the patient filled a prescription for 30 tablets of Percocet prescribed by Respondent. Despite documenting the patient's concern regarding her Percocet use in November 2017, Respondent did not document any discussions with the patient regarding the risks, benefits and alternatives to opioids for pain relief.

49. On May 4, 2018, Patient 1 was seen by Respondent for complaints of a purulent discharge from her surgical incision as well as severe constipation. She stated she went to the emergency room for the constipation and was diagnosed with rectocele (posterior vaginal prolapse). She stated that she was not feeling well and that she believed that her medications were "too heavy." Respondent noted that she was taking Cymbalta, gabapentin, Xanax, Trazadone, and Rexulti. Respondent resected the incision with stitch granuloma. Respondent recommended repair of the rectocele and decreased the patient's trazodone from 100 milligrams every night to 50 milligrams every night.

50. On June 22, 2018, Respondent performed a posterior colporrhaphy[4] to correct the rectocele and superficial nerve block for the superficial hypogastric neuralgia. That same day, Respondent prescribed 30 tablets of Percocet to the patient. Respondent did not document any discussions with the patient regarding the risks, benefits and alternatives to opioids for pain relief.

51. In or around December of 2018, Patient 1 suffered from a drug overdose. Patient 1's medical records document that she called her primary care physician On December 7, 2018, to request a referral to Loma Linda University's Behavioral Medical Clinic as soon as possible as she was recently hospitalized for a drug overdose.

Patient 2:

52. Patient 2, a then 60-year-old male, presented to Respondent on October 3, 2018, with a complaint of anxiety. The patient stated that he was worried about the upcoming one-year anniversary of his mother's death and was anxious for his father, who is in his nineties. Patient 2 requested anxiety medication. Respondent noted that he had no concerns about severe depression

[4] Colporrhaphy, also known as vaginal wall repair, is a surgical procedure performed to correct defects in the vaginal wall, or pelvic-organ prolapse.

and no suicidal or homicidal ideations. Respondent performed a limited assessment of the patient's psychological status and function. Respondent did not document any assessment of prior drug use or dependence. Respondent assessed the patient as having situational anxiety. He prescribed Xanax to the patient (to be taken as needed, with one refill). Respondent noted that he obtained informed consent from the patient and that the patient would notify him if any other issues arise. However, Respondent failed to obtain a specific documented informed consent for treatment with a controlled substance that was signed by the patient.

53. Patient 2 filled prescriptions for 90 tablets of Xanax prescribed by Respondent on each of the following dates: October 12, 2018, December 5, 2018, and January 3, 2019.

54. On March 1, 2019, Patient 2 called Respondent and requested a refill of his prescription for Xanax. Respondent noted that the patient would follow-up as needed. Respondent failed to document any indications for refilling Patient 2's Xanax prescription and refilled the prescriptions without seeing him.

55. On April 12, 2019, Patient 2 filled a prescription for 90 tablets of Xanax prescribed by Respondent.

56. On February 12, 2020, Patient 2 presented to Respondent with complaints of stress and anxiety. He stated that he worked long hours while taking care of his elderly father. He stated that he had been experiencing episodes of palpitations and needed to take deep breaths. He reported no cardiac issues. Respondent's review of Patient 2's systems was noted to be within normal limits, other than the patient feeling stressed and tired. The patient's physical examination was documented to be essentially within normal limits. Respondent performed an assessment of the patient's psychological status and function. There was no documentation of any assessment of the patient's prior drug use or dependence. Respondent noted that the patient was slightly anxious with no agitation. The patient signed a written informed consent for opioid therapy and a written consent of understanding of driving while using opioid/benzodiazepine medications. Patient 2 was screened for adult anxiety related disorders. Respondent's impression was situational anxiety. He prescribed Xanax (1 to be taken up to three times a day).

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57. On February 24, 2020, and April 4, 2020, Patient 2 filled prescriptions for 90 tablets of Xanax prescribed by Respondent.

58. On May 11, 2020, Respondent documented "contact" with Patient 2, noting that the patient was doing well and was stable. Respondent did not specify the manner of his contact with Patient 2. The patient reported appropriate medication use. Respondent instructed the patient to follow-up in person in the next two to three months.

59. On July 1, 2020, Patient 2 filled a prescription for 90 tablets of Xanax prescribed by Respondent.

60. On July 30, 2020, Patient 2 presented to Respondent for a formal follow-up. He stated that his anxiety had improved somewhat and that only took Xanax on February 24, 2020 and April 29, 2020. Respondent assessed the patient with situational anxiety. He recommended that the patient stay off Xanax, but continue to take his blood pressure medications. Respondent noted that while the patient's primary care physician could offer him preventative care, the patient could also follow-up with Respondent, as needed.

Patient 3:

61. Patient 3, a then 58-year-old female patient, was referred to Respondent in or around October 2015, following a diagnosis of uterine and bladder prolapse. She first presented to Respondent on October 19, 2015, at which time Respondent assessed her as having bladder prolapse, second degree uterine prolapse, and incontinence stress. She was noted to be very symptomatic with pressure as well as occasional stress urinary incontinence. Respondent recommended a colporrhaphy with possible colposuspension.

62. On November 9, 2015, Patient 3 underwent a total vaginal hysterectomy at San Gorgonio Memorial Hospital secondary to uterine prolapse with possible vaginal wall prolapse.

63. On November 12, 2015, Respondent prescribed 40 tablets of Norco to Patient 3. Respondent did not document any discussion of the risks of opioid use or document a clearly defined treatment objective for opioid treatment.

64. Patient 3 was seen by Respondent for a post-operative visit on December 7, 2015. Upon examination, Respondent noted normal post-operative findings with healing and a little bit

of inflammation. Patient 3 requested pain medication. Respondent provided her with a prescription for 30 tablets of Norco and instructed her to return for follow-up visit in one month. Respondent did not document any discussion of the risks of opioid use or document a clearly defined treatment objective for opioid treatment.

65. Patient 3 returned to see Respondent for a post-operative visit on January 6, 2016, at which time she complained of pelvic and lower back pain radiating to her buttocks. Respondent recommended an MRI to determine if the pain was in the lower spine or confined to the pelvis. Respondent noted that the patient requested pain medication. He gave her a prescription for Norco. Respondent did not document any discussion of the risks of opioid use or document a clearly defined treatment objective for opioid treatment.

66. On January 21, 2016, Patient 3 left a message for Respondent requesting a refill of Norco. Respondent stated that the patient needed to be seen at the office or the UCC for a narcotic refill.

67. On February 24, 2016, Patient 3 was seen by Respondent for a follow-up visit. She reported right groin pain, a pulling sensation in the buttocks, and significant discomfort. She had an MRI of the abdomen and pelvis that was essentially negative with a small insignificant left 2.1 cm ovarian cyst. Respondent recommended that the patient be examined under anesthesia with a vaginal cuff takedown with possible excision of neuroma or a granuloma. He prescribed 30 tablets of Percocet to her. Respondent failed to document performing any periodic review of Patient 3's pain treatment, any discussion of the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

68. On March 1, 2016, Patient 3 left a message for Respondent that the pharmacies in her area did not have Percocet and she requested Norco instead. The next day Respondent told her that he could not provide a prescription for Norco to her unless she returned the Percocet pills to him.

69. On March 16, 2016, Respondent saw Patient 3 at a follow-up visit. The patient stated that her bladder had fallen and was at the introitus. She asked him if she could have her cystocele repaired at the time of her examination under anesthesia and possible vaginal cuff take down.

70. On March 28, 2016, Patient 3 underwent an apical colporrhaphy with apical adesiolysis for cystocele and pelvic pain. Respondent noted that the patient tolerated the procedure well and was sent home with Percocet and antibiotics.

71. On April 14, 2016, Patient 3 presented to Respondent for a post-operative visit. She complained of a pulling sensation and stated that oxycodone relieved some of the pain. Respondent noted that she was healing well. He gave her a prescription for Norco and instructed to follow-up in 3 months. Respondent did not document performing a periodic review of Patient 3's pain treatment, any discussion of the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

72. On June 15, 2016, Patient 3 presented to Respondent for a 3-month follow-up visit. She complained of a white bump on the inside of the left vulva and discharge. She stated that she has been using Motrin with no relief and requested Norco. Upon examination, Respondent noted a plastic lesion approximately 2 cm in length on the inner aspect of the left labium suspicious for vulvar intraepithelial neoplasia. Respondent recommended excision of the lesion and gave the patient a prescription for Norco. Respondent did not document performing a periodic review of Patient 3's pain treatment. He did not document any discussion with the patient about the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

73. On July 25, 2016, Respondent performed a wide local excision of the left lower labium. Pathology revealed high-grade squamous intraepithelial neoplasia. Respondent referred Patient 3 to a gynecological oncologist. On September 16, 2016, Dr. Y.I. performed a partial vulvectomy, vulvovaginal colposcopy and multiple vulvar biopsies. The patient's margins were negative.

74. On November 29, 2017, Patient 3 was seen by Respondent for complaints of pelvic pain, a cyst on her ovary, and bladder prolapse. Respondent recommended a colporrhaphy and ovariectomy. Respondent noted that the patient is "on Percocet by PCP." Surgery was scheduled for February 13, 2018, at Redlands Hospital.

75. On December 13, 2017, Respondent prescribed 30 tablets of Percocet to Patient 3. Respondent did not document performing a periodic review of Patient 3's pain treatment. He did

not document any discussion with the patient about the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

76. On December 27, 2017, Respondent received correspondence from Optum Rx indicating that Patient 3 had received opioid therapy for pain management from at least three prescribers in the last sixty days and to please consider re-evaluating the patient's pain management therapy. Respondent failed to take or document any action in response to the correspondence.

77. On January 8, 2018, Patient 3 presented to her primary care physician, Dr. R.S. for surgery clearance. Dr. R.S. documented discussing the patient's narcotic medications and daily narcotic use for chronic pain, including chronic back pain, arthritis, and multiple joint pain. Dr. R.S. noted that the patient had not shown evidence of diversion or escalation of dosage. He indicated that a pain contract would be necessary and CURES reports would be scanned into her Patient chart. Cystocele was schedule to take place in two weeks for her inability to control bladder and pelvic pain.

78. On January 25, 2018, Patient 3 executed a pain management agreement. It was counter signed by Dr. R.S.

79. On February 16, 2018, Respondent performed a cystocele on Patient 3. That same day, he prescribed 30 tablets of Norco. Respondent did not document acknowledging the pain management agreement Patient 3 entered into on January 25, 2018 with Dr. R.S., nor did he document performing a periodic review of Patient 3's pain treatment, any discussion with the patient about the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

80. On February 21, 2018, Patient 3 presented to Respondent for a post-operative visit. She complained of pelvic pain. Her Foley catheter was removed and she was prescribed antibiotics for a urinary tract infection. Patient 3 also complained of pain and requested that her pain medications be refilled. At that time, Respondent also prescribed 40 tablets of Norco and instructed the patient to return in three months. Respondent did not document acknowledging the pain management agreement Patient 3 entered into on January 25, 2018, with Dr. R.S., nor did he

document performing a periodic review of Patient 3's pain treatment, any discussion with the patient about the risks of long-term opioid use, or a clearly defined treatment objective for opioid treatment.

81. Patient 3 next presented to Respondent on March 8, 2018. Her incisions were noted to have healed. She was told that she could return to work and was instructed to return in six months.

82. On September 26, 2018, Patient 3 was seen for complaints of pelvic pain. Respondent ordered an ultrasound for the pelvic pain.

83. On September 28, 2018, Patient 3 underwent a pelvic and transvaginal ultrasound, which did not reveal any free fluid or pelvic masses.

84. That same day, Patient 3 was seen by Dr. R.S. about her chronic pelvic pain. She stated that she was disappointed with Respondent because he ordered a pelvic ultrasound, did not examine her, and only gave her 90 tablets of Norco when she should have received 120 tablets. Dr. R.S. noted that the patient's CURES report was checked and there were no suspicious findings. The patient complained of gross blood in her urine (on and off), but did not have any today. She denied flank pain, and had no increased urgency, no burning sensation and no symptoms of urinary tract infection. Dr. R.S. ordered a renal ultrasound to rule out kidney stones and noted that he would follow-up with Respondent for her pelvic ultrasound results.

85. On October 28, 2018, Respondent notified Patient 3 that her pelvic ultrasound results were normal.

Patient 4:

86. On February 23, 2017, Patient 4, a then 23-year-old female, presented to Respondent with complaints of sharp, continuous stabbing and lower abdominal pain. She was referred to Respondent by her primary care physician for a gynecological evaluation. Respondent noted that the patient had a past history of a cesarean delivery in 2013 and has been prescribed tramadol for the pain. Respondent recommended an ultrasound and determined that depending on the results, she might need a laparoscopy. In the "Patient Instructions" portion of the progress note, Respondent noted that the patient would be undergoing a laparoscopy at San Gorgonio Medical

Center. The patient was provided with preoperative instructions and prescriptions, and the risks, benefits and alternatives to the operation were discussed with her and her informed consent was obtained.

87. On February 24, 2017, Patient 4 left a message for Respondent stating that she had taken tramadol, but it did not help her with her pain. Respondent prescribed 30 tablets of Tylenol with Codeine No. 3. Respondent failed to discuss and document discussing the risks and benefits of Tylenol with Codeine No. 3 with the patient.

88. On April 12, 2017, Respondent saw Patient 4 for a preoperative visit and to discuss alternatives; laparoscopy surgery versus a laparotomy. Her surgery was scheduled for June 26, 2017 at Inland Surgery Center.

89. On June 26, 2017, Patient 4 underwent a diagnostic laparoscopy with lysis of omental fascial adhesions. She was noted to have tolerated the procedure well. Respondent prescribed Norco (10 mg) to the patient and instructed her to follow-up with Respondent in August. He did not document the indication for prescribing Norco to the patient nor did he document any discussion of the risks and benefits of Norco with the patient.

90. Respondent saw Patient 4 On August 31, 2017, at which time she complained of pelvic pain. She stated that the pain had already recurred and was severe. Respondent noted that the patient might have deep endometriosis. They discussed treatment with Zoladex, an implant placed by injection under the skin of the lower abdomen that slowly releases a hormone into the body.

91. On September 6, 2017, Patient 4 left a message for Respondent complaining that Tylenol No. 3 was giving her nausea and itchiness. She requested a different pain medication. On September 11, 2017, Respondent documented that the patient would not be given pain medication without being seen.

92. Respondent saw Patient 4 on September 15, 2017, at which time she complained of pelvic pain. She stated that she went to the emergency department and was told that she has an ovarian cyst. In the emergency department, she was prescribed Norco and promethazine, an antihistamine. The patient had her first Zoladex injection for pelvic pain. Respondent ordered a

pelvic ultrasound and prescribed Percocet for the patient, and instructed her to return in 10 days.

93. On September 28, 2017, Patient 4 underwent a pelvic ultrasound, which showed a cyst on the right ovary measuring 0.51 cm. On October 20, 2017, the patient underwent another Zoladex injection for the pelvic pain.

94. On November 1, 2017, Patient 4 presented to Respondent with complaints of severe pain and pressure with bloating for the past 2 days, and that she had thrown up. She had undergone two Zoladex injections. Respondent's impression was pelvic pain with some gastro-intestinal symptoms. He ordered an upper gastrointestinal series (upper GI), liver function studies and a transvaginal ultrasound. He instructed the patient to continue with the Zoladex, and prescribed 30 tablets of Zoloft (50 mg). He did not document the indication for prescribing Zoloft to the patient, nor did he document discussing the risks and benefits of Zoloft with the patient.

95. On November 8, 2017, the patient underwent an ultrasound examination of the pelvis with unremarkable results.

96. On November 17, 2017 and December 19, 2017, Patient 4 had Zoladex injections for pelvic pain.

97. On December 19, 2017, Patient 4 called Respondent's office requesting pain medication. She stated that tramadol was not enough and Percocet was too strong. Respondent prescribed 30 tablets of Norco (5 mg) to her. He did not document the indication for prescribing Norco to her and did not document discussing the risks and benefits of Norco with her.

98. On January 23, 2018, Patient 4 had a Zoladex injection for pelvic pain.

99. On February 5, 2018, Patient 4 requested a refill of her pain medication. Respondent stated that the patient would need to be seen before Schedule II medications would be prescribed for her.

100. On May 23, 2018, Patient 4 underwent a Zoladex injection for pelvic pain. She stated that she has noticed an improvement in her pain. Respondent instructed her to return in three months for a reassessment. She was prescribed birth control medication and 30 tablets of Norco (5 mg) at the visit. Respondent failed to document the indication for prescribing Norco to her,

and failed to document discussing the risks and benefits of Norco with her.

101. On June 6, 2018, Patient 4 was seen by Respondent at a follow-up visit. She complained of the recurrence of pain. Respondent recommended a presacral neurectomy[5] with laparoscopic lysis of adhesions, possible right salpingo-oophorectomy, and possible exploratory laparotomy. Respondent scheduled the patient for surgery and prescribed 15 tablets of Percocet (5 mg) and 30 tablets of tramadol. Respondent failed to document the indication for prescribing Percocet and tramadol to the patient, and failed to document discussing the risks and benefits of Percocet and tramadol with her.

102. On August 1, 2018, Patient 4 was seen by Respondent and stated that the pain had returned. She stated that she does not want surgery before October 2018 and requested a refill of Percocet. He noted that the patient would be transferring her care to Inland Women's Care Associates[6] where Respondent would continue to provide obstetrical and gynecology services to her.

103. In or around February 2020, Patient 4 transferred back to Beaver Medical Group and began receiving prenatal care by Respondent for a planned pregnancy. The patient's child was delivered by cesarean section On March 29, 2020. On March 31, 2020, Respondent prescribed 10 tablets of Norco (to be taken as needed every six hours for five days).

104. On April 1, 2020, Patient 4 complained of acute post-operative pain and stated that she had consumed all but two remaining tablets of the Norco prescribed to her. Respondent arranged for a telemedicine visit for the management of the patient's acute post-operative pain and prescribed 20 tablets of Percocet (10 mg) to her for her post-operative pain. Respondent failed to document any discussion with Patient 4 regarding the risks and benefits of controlled substances.

105. On April 17, 2020, Respondent prescribed 20 tablets of Percocet (10 mg) for Patient 4's post-operative pain. Respondent failed to document any discussion with Patient 4 regarding

[5] Presacral neurectomy is the surgical removal of the presacral plexus, the group of nerves that conducts pain signal form the uterus to the brain.

[6] Inland Women's Care Associates provides obstetrical and gynecological services to women with Medi-Cal and Inland Empire Health Plan insurances.

the risks and benefits of controlled substances.

106. On May 1, 2020, Respondent prescribed 90 tablets of Zoloft to the patient for anxiety and depression. Respondent failed to document any discussion with Patient 4 regarding the risks and benefits of taking Zoloft.

Patient 5:

107. On September 19, 2016, Patient 5, a then 29-year-old female patient first presented to Respondent with complaints of pelvic pain. She had been given a diagnosis of pelvic inflammatory disease at the UCC. Previously, she had a Loop Electrosurgical Excision Procedure (LEEP)[7] in July 2016. She was noted to be human papillomavirus infection (HPV) positive with an abnormal pap smear. Respondent's impression was that the patient likely had cervix-cervicitis. Respondent noted that a diagnosis of cervical inflammation may be premature and reassured the patient that her symptoms were consistent with a diagnosis of inflammation status post LEEP with granulation tissue. He recommended follow-up in one month. He prescribed 15 tablets of Norco and 30 tablets of tramadol to Patient 5. Respondent to assess the patient's past substance abuse or document the same. Respondent failed to document any indications for the use of controlled substances and the option of alternative therapies for Patient 5.

108. On September 30, 2016, Patient 5 left a message for Respondent that she needed a refill for Percocet. She had been prescribed Norco the previous day and Patient 5 alleged that it was not working. Respondent prescribed 30 tablets of Percocet to Patient 5 (to be taken every six hours, as needed). Patient 5 was advised to pick up the prescription and make an appointment. He did not document the indication for prescribing Percocet and did not document any discussion of the risks and benefits of using Percocet.

109. On October 4, 2016, Patient 5 called Respondent requesting another refill of Percocet. She stated that she had been taking two Percocet at a time and would soon exhaust her supply. She had also started her period, so her pain was worse. She was offered an appointment to see Respondent the following day, but declined stating she would need an exam. Respondent stated

[7] A LEEP is a procedure to remove abnormal tissue from the cervix using a wire loop heated by electric current.

that Patient 5 needed to be seen for a prescription.

110. On October 6, 2016, Patient 5 presented to Respondent for a follow-up and a refill of her medications. She complained of pelvic pain similar to strong menstrual cramp after sex. Respondent noted that her pelvic pain required more than Norco "at this point." Respondent recommended a diagnostic laparoscopy.

111. On October 10, 2016, and October 11, 2016, Patient 5 left messages for Respondent requesting pain medication because she would be going out of the country and would run out of Percocet while she was gone. Respondent stated that she needed to be seen for an appointment and that if the pain was severe, she needed to present to the emergency department, the UCC or her primary care physician.

112. On October 11, 2016, Patient 5 was seen by another physician in Respondent's practice, Dr. S.G., for complaints of pain and severe cramps with sex. She was assessed with cervix-cervicitis and prescribed 90 tablets of Percocet. Dr. S.G. noted that she discussed the medication, adverse effects, uses and expected results with the patient.

113. On October 19, 2016, Patient 5 left a message for Respondent stating that she came back from Germany early because she did not want to run out of her medications while she was out of the country. She requested medication that was not as strong as Percocet for daytime use and Respondent had prescribed toradol. She stated that toradol did not help her with her pain and requested tramadol.

114. On October 25, 2016, Respondent prescribed 30 tablets of tramadol to Patient 5. Respondent failed to document a diagnosis or any indications for the use of tramadol.

115. On October 31, 2016, Patient 5 presented to Respondent at a follow-up visit. Her diagnostic laparoscopy was scheduled for November 28, 2016. She was prescribed 40 tablets of Percocet for her continued pain and Respondent noted that it should last her until the surgery. Respondent failed to document any indications for the use of Percocet, the risks associated with its use, or Patient 5's response to treatment with Percocet.

116. When Patient 5 attempted to pick up her Percocet prescription, the pharmacy called Respondent to report that Patient 5 had just picked up a prescription for 90 tablets of Percocet On

October 11, 2016, and that she would like something else because her insurance will not cover more Percocet. In response, Respondent prescribed Tylenol with Codeine No. 3. Respondent failed to document the indications for the Tylenol with Codeine No. 3 and the risks associated with its use.

117. On November 9, 2016, and again on November 14, 2016, Respondent prescribed 30 tablets of tramadol to be taken every 6 to 8 hours for pain as needed. Respondent did not document the indications for the use of tramadol, the risks associated with its use or Patient 5's response to treatment with tramadol.

118. On November 21, 2016, at 8:10 a.m., Patient 5 called Respondent requesting a prescription for Percocet because the tramadol was not helping with her pain. At 9:25 a.m., Respondent denied a Percocet prescription for Patient 5 and instructed her to double the tramadol dose or take Motrin between tramadol doses.

119. That same morning, Respondent prescribed 20 tablets of Percocet to Patient 5. The prescription was documented in the patient's chart without any explanation or documented diagnosis.

120. On November 22, 2016, the Inland Surgery Center notified Respondent that Patient 5 cancelled her surgery scheduled for November 28th because she needed to pick up her father from the airport. The note further stated that Patient 5 had been consistently calling for refills of her pain medications. Respondent stated that she would not be provided any more pain medications.

121. On November 28, 2016, Respondent prescribed 30 tablets of tramadol and her surgery was rescheduled for January 23, 2017. Respondent did not document any indications for the use of tramadol, the risks associated with its use or Patient 5's response to treatment with tramadol.

122. On December 1, 2016, Patient 5 called for a refill of her pain medications. Respondent stated that the patient needed to be seen by him in person, that a pain contract needed to be signed, and that it was unacceptable to doctor shop within the Beaver Medical Clinic.

123. On December 9, 2016, Respondent prescribed 40 tablets of tramadol. Respondent did not document the indications for the use of tramadol, the risks associated with its use or Patient

5's response to treatment with tramadol.

124. That same day, Patient 5 called Respondent's office to request a change in pain medication because the tramadol and her Lexapro is making her anxious. She would like to pick up new prescription but does not want to check-in and pay another copayment. Respondent stated that the patient needed to return to the clinic for further evaluation and that he was worried that she was attempting to get controlled medications from other doctors at Beaver Medical Clinic even though she had a pain medication contract.

125. On December 20, 2016, Respondent prescribed 30 tablets of tramadol. Respondent failed to document the indications for the use of tramadol, the risks associated with its use, or the Patient 5's response to treatment with tramadol.

126. On December 28, 2018, Patient 5 presented to the UCC for complaining of pain secondary to endometriosis and requested Percocet. She reported that she had surgery scheduled for January 20th and did not do well on tramadol. She declined a Toradol injection. She stated that the pain was not bad enough for an injection, but insisted on obtaining Norco. It was noted that she was given five pills. That same day, Patient 5 called requesting more pills. Suspicious activity was noted and Dr. M.S. stated that there was no pain contract on file, no urine drug screen, and no metabolic panel. He denied Patient 5's request for pain medication. He ordered that the patient re-evaluated and a blood test performed prior to any medication refill.

127. On January 4, 2017, Patient 5 called again for a refill of pain medications and was informed that she would need to be seen for any pain medication refills.

128. On January 20, 2017, Respondent saw Patient 5 for her annual examination and preoperative appointment. At that time, Patient 5 stated that she did not have serious complaints other than pelvic pain and wanted to try alternatives to surgery. Respondent noted that he discussed the history of pelvic pain, possible endometrioses, and empiric treatment with Zoladex with the patient. She was instructed to return in 6 months.

129. On April 28, 2017, Patient 5 called the UCC and requested gabapentin. She was instructed to come in for an evaluation. That same day, she presented for an evaluation at the UCC and requested gabapentin to treat her anxiety. She was noted to have been hospitalized for

alcohol, opiate, and benzodiazepine addiction, and had been in remission for 90-day.

130. On May 4, 2017, Patient 5 was seen by Respondent for contraception management.

STANDARD OF CARE

131. When prescribing pain medications, the standard of care requires that the physician take a medical history and perform a physical exam. The medical history should include the patient's substance abuse history, history of prior treatments, and history of prior pain treatments. The physical examination should include an assessment of the patient's physical and psychological status and function, physical pain, and any other underlying or co-existing conditions. The physician should include documentation of medical indications for the use of controlled substances and response to treatment, including relief of pain and improved physical or psychological function. The physician should also document discussion with the patient regarding the risks and benefits of controlled substance use along with other possible treatment modalities.

132. While it is acceptable for a physician to utilize pain medications to manage pain in the pre-operative and post-operative period, prescribing pain medications outside the pre-operative and post-operative periods, requires that the physician develop a treatment plan, conduct ongoing pain assessments with close follow-up office visits, periodic reviews of the patient's pain treatment, discuss the long-term effects of the use of pain medications, discuss the risks of potential overdose or addiction, and have the patient enter into a pain management agreement.

133. For patients with certain presenting conditions and underlying psychiatric issues, the standard of care requires that a physician refer the patient to a pain specialist for management of pain and the prescribing of pain medications.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence in the Care and Treatment of Patients 1, 4, and 5)

134. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in his care and treatment of Patients 1, 4, and 5. Complainant refers to and, by this reference incorporates herein, paragraphs 16 through 51, and

86 through 133, above, as though fully set forth herein. The circumstances are as follows:

Patient 1:

135. Beginning in or around May 2015 and thereafter, Respondent committed gross negligence in connection with his management of Patient 1's chronic pain with narcotics. Respondent failed to properly manage Patient 1's chronic pain and prescribed controlled substances without developing a treatment plan and conducting ongoing pain assessments with close follow-up office visits. On multiple occasions, Respondent prescribed controlled substances in response to Patient 1's telephone requests for pain medication and within close intervals of controlled substances that had already been prescribed, including, prescribing Tylenol with Codeine No. 4 and tramadol on the same day Patient 1 filled a prescription for Percocet without any discussion of the potential danger and risk of overdose and/or death when taking multiple opioids. Respondent failed to document any discussions with the patient of the long-term effects of the use of pain medications and the risks of potential overdose or addiction, failed to have Patient 1 enter into a pain management agreement despite prescribing pain medications over a four-year period of time, and failed to refer Patient 1 to a pain management specialist when the patient was receiving treatment for psychiatric issues.

Patient 4:

136. On or about February 23, 2017 and thereafter, Respondent committed gross negligence in connection with his management of Patient 4 endometriosis with medications. Respondent prescribed opioids to Patient 4 on at least 16 occasions over a three-year period. During that time, Respondent failed to exhaust all non-narcotic treatments for painful endometriosis, failed to discuss the risks of opioid use, failed to develop a treatment plan for opioid use, and failed to refer the patient to a pain management specialist for long-term opioid use; and failed to adequately document any of the foregoing.

Patient 5:

137. On or about September 19, 2016 and thereafter, Respondent committed gross negligence in connection with his care for Patient 5 as follows: Respondent failed to properly manage Patient 5's chronic pain and prescribed controlled substances, without developing a

treatment plan and conducting ongoing pain assessments with close follow-up office visits. On multiple occasions, Respondent prescribed controlled substances in response to Patient 5's telephone requests for pain medication and within close intervals of controlled substances already being prescribed, without any discussion of the potential danger and risk of overdose and/or death when taking multiple opioids. Respondent failed to document any discussions of the long-term effects of the use of pain medications and the risks of potential overdose or addiction, and failed to have Patient 5 enter into a pain management agreement despite prescribing pain medications over a two-year period of time.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

138. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1, 2, 3, 4, and 5. Complainant refers to and, by this reference, incorporates herein, paragraphs 16 through 138, above, as though fully set forth herein. The circumstances are as follows:

139. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

Patient 1:

140. Beginning in or around May 2015 and thereafter, Respondent committed the following negligence in connection with his care and treatment of Patient 1:

A. Respondent failed to adequately develop a treatment plan for Patient 1's long-term use of controlled substances.

B. Respondent failed to adequately conduct pain assessments and re-assessments with close follow-up office visits while continuing to prescribe controlled substances to Patient 1.

C. Respondent inappropriately prescribed controlled substances to Patient 1, including, when Respondent prescribed, Tylenol with Codeine No. 4 and tramadol on the same day Patient 1 filled a prescription for Percocet, without any documented discussion with the patient about the potential danger and risk of overdose and/or death when taking multiple opioids.

D. Respondent failed to adequately document any discussions with Patient 1 about

the long-term effects of the use of pain medications and the risks of potential overdose or addiction.

E. Respondent failed to have Patient 1 enter into a pain management agreement despite prescribing pain medications over a four-year period of time.

F. Respondent failed to refer Patient 1 to a pain management specialist when the patient was receiving treatment, including medications, for psychiatric issues.

Patient 2:

141. Beginning on or about October 3, 2018 and thereafter, Respondent committed the following negligence in connection with his care and treatment of Patient 2:

A. Respondent failed to adequately document a comprehensive history for this patient, including, when Respondent prescribed Xanax to Patient 2 on October 3, 2018, and failed to document a comprehensive history, including the patient's prior drug use or dependence.

B. Respondent also failed to adequately document indications for drug refills to this patient, including following Patient 2's visit with Respondent on October 3, 2018, when Respondent refilled Patient 2's Xanax prescriptions on four occasions without seeing the patient and without documenting the indications for the refills.

C. Respondent also failed to obtain an informed consent from the patient, and/or document the same, including when Respondent began prescribing Xanax to Patient 2 on October 3, 2018, and failed to obtain the patient's informed consent for treatment with a controlled substance, until February 12, 2020, at which time Xanax had been prescribed on at least four occasions.

Patient 3:

142. From 2015 through 2018, Respondent committed the following negligence in connection with his care and treatment of Patient 3:

A. Respondent failed to adequately document any discussion with the patient about the risks of opioid use.

B. Respondent failed to adequately document a clearly defined objective for the patient's opioid treatment.

C. Respondent failed to perform adequate periodic reviews of the patient's pain treatment.

Patient 4:

143. On February 23, 2017 and thereafter, Respondent committed the following negligence in connection with his care and treatment of Patient 4:

A. Respondent failed to adequately document the indication for prescribing controlled substances to Patient 4.

B. Respondent failed to adequately document any discussion of the risks and benefits of opioid use when he prescribed controlled substances to Patient 4.

Patient 5:

144. On or about September 19, 2016 and thereafter, Respondent committed the following negligence in connection with his care and treatment of Patient 5, as follows:

A. Respondent failed to adequately document Patient 5's prior substance abuse history before prescribing controlled substances.

B. Respondent repeatedly prescribed controlled substances to Patient 5 without a clear indication for their use.

C. Respondent repeatedly prescribed controlled substances to Patient 5 without documenting a response to treatment.

D. Respondent failed to discuss the risks associated with controlled substances with Patient 5.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

145. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1, 2, 3, 4, and 5 without an appropriate prior examination and/or medical indication. Complainant refers to and, by this reference, incorporates herein, paragraphs 16 through 144, above, as though fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

146. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patients 1, 2, 3, 4, and 5. Complainant refers to and, by this reference, incorporates herein, paragraphs 16 through 145, above, as though fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct – Patients 1 and 5)

147. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that his action and/or actions represent unprofessional conduct, generally, and patient harm occurred as a result. Complainant refers to and, by this reference, incorporates herein, paragraphs 16 through 51, 107 through 130, 134 through 135, 137 through 140, and 144, above, as though fully set forth herein. The circumstances are as follows:

148. As more fully discussed above, Respondent's excessive prescribing of controlled substances, including opioids and other drugs caused specific harm to Patients 1 and 5 for purposes of Code section 2228.1 as further described below:

A. Patient 1 suffered harm due to Respondent's management of Patient 1's chronic pain with narcotics, which culminated in her drug overdose in December of 2018. Respondent's prescribing of controlled substances during the course of his care and treatment of her, contributed to her addiction, and she suffered a subsequent drug overdose.

B. Patient 5 suffered harm as a result of Respondent's prescribing of controlled substances to her during the course of his care and treatment of her and his actions contributed to her narcotic abuse which required hospitalization and drug rehabilitation in 2017.

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SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

149. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records for Patients 1, 2, 3, 4, and 5. Complainant refers to and, by this reference, incorporates herein, paragraphs 30 through 144, above, as though fully set forth herein.

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 87408, issued to Respondent Karim Tousarkissian, M.D.;

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

3. Ordering Respondent Karim Toursarkissian, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. If disciplined, ordering Respondent Karim Toursarkissian, M.D., to disclose his discipline to patients as required by section 2228.1 of the Code; and

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

DATED: MAY 31 2022

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

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