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

In the Matter of the Accusation Against:	)	
TUAN ANH DOAN, M.D.	)	Case No. 8002014007305
Physician's and Surgeon's Certificate No. G77825	)	OAH No. 2016090221.1
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 5, 2018.

IT IS SO ORDERED: December 6, 2017.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: TUAN ANH DOAN, M.D. Rocklin, California Physician's and Surgeon's Certificate No. G 77825 Respondent.	MB No. 800-2014-007305 OAH No. 2016090221.1

PROPOSED DECISION

This matter was heard before Administrative Law Judge Erin R. Koch-Goodman, Office of Administrative Hearings (OAH), State of California, on September 5 through 8, and 11 through 13, 2017, in Sacramento, California.

John S. Gatschet, Deputy Attorney General, appeared on behalf of Kimberly Kirchmeyer (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Bruce W. Ebert, PhD, Attorney at Law, appeared on behalf of Tuan Anh Doan, M.D. (respondent), who was present at hearing.

Evidence was received at hearing. The record remained open for the submission of simultaneous written closing briefs, filed and served, by close of business October 16, 2017. Complainant's and Respondent's Closing Briefs were received by OAH on October 16, 2017, and marked as Exhibits 52 and Z, respectively. The matter was submitted for decision on October 16, 2017.

FACTUAL FINDINGS

1. On October 27, 1993, the Board issued respondent Physician's and Surgeon's Certificate (license) No. G 77825. Respondent's license is in full force and effect until March 31, 2019, unless renewed or revoked.

Complaint

2. On July 30, 2014, Sutter Medical Group (Sutter) filed a Health Facility Reporting Form (805 Complaint) with the Board, alleging several deficiencies in respondent's care and treatment of patients. The complaint detailed the following information regarding respondent's pain management practices: On May 3, 2013, Sutter met with respondent to discuss deficiencies in his pain management practices. On November 12, 2013, Sutter again met with respondent to discuss failures in his patient care communication; specifically, leaving patient calls open for up to 45 days, in violation of Sutter policy. In February 2014, Sutter began an audit of respondent's chronic pain patients. The findings were presented to respondent on May 16, 2014, showing the following deficiencies: 23 charts without pain contracts or outdated contracts; 11 uncharted drug screen abnormalities; 26 charts showing excessive prescribing of narcotics, tranquilizers, and/or muscle relaxers; 14 charts did not contain drug screens; 4 charts showed the patient had not been seen for more than three months; and 4 charts showed early refills of pain medication in violation of a pain contract, with no explanation in the chart.

Beginning May 16, 2014, Sutter began another audit of respondent's charts, finding: a number of abnormal drug screens without any action taken and then narcotic prescriptions written; when a warning letter was issued to a patient regarding an abnormal drug screen, indicating the narcotic would be discontinued, however, at the next appointment, respondent refilled the narcotic prescription; some charts indicated the pain agreement was updated and drug screen ordered, when neither were true, and respondent would refill a narcotic prescription at the next appointment; multiple calls from pharmacies unwilling to fill narcotic prescriptions written by respondent; narcotic prescriptions written without documentation in the medical record; and an instance of decreasing narcotics too quickly without a weaning regime. From May 2013, through May 2014, respondent was issued written warnings with increasing discipline. Respondent was unable to cure his deficiencies, and on July 16, 2014, Sutter terminated his employment.

3. The Board reviewed the complaint, opened an investigation, and subpoenaed respondent's patient medical records from Sutter for the period January 1, 2012, through July 30, 2014, and from respondent's private practice for the period July 31, 2014, through February 27, 2015.[1] All patient medical records were created using an Electronic Medical Record (EMR) system: Sutter uses EPIC and respondent's solo practice uses Chart-Perfect. The Board retained two experts, Christopher Chisholm, M.D., pain specialist, and Norman Bensky, M.D., family practice, to determine whether respondent practiced within the standard of care for a family practice doctor.

Accusation

4. On August 5, 2016, complainant, in her official capacity, made and served the instant Accusation, seeking discipline against respondent's license. Complainant alleges that

[1] In 2015, respondent opened a private practice office in Rocklin.

respondent committed repeated acts of negligence, as well as failed to maintain adequate and accurate medical records during his treatment of Patients CB, MJ, KL, and CG. Specifically, complainant alleges respondent failed to: (1) periodically review and document a substance abuse history for Patients CB, MJ, KL, and CG; and (2) obtain informed consent from Patients CB, MJ, and CG prior to initiating opioid therapy. On August 22, 2016, respondent timely filed a Notice of Defense.

PATIENT CB

5. To evaluate respondent's documentation, a review was made of Patient CB's medical records, from January 1, 2012, to July 30, 2014. Patient CB was seen by respondent for chronic pain management. Respondent prescribed opioids to Patient CB, beginning on April 17, 2012. The medical records fail to document any informed consent discussions between respondent and Patient CB regarding the risks and benefits of taking opioid medication. At times, Patient CB exhibited notable behavior for a patient prescribed opioids. For example, on one occasion, Patient CB asked for an early refill of her opioid medication, indicating she had exhausted her supply; and on another occasion, Patient CB asked for an early refill of her opioid medication, indicating she was in a motor vehicle accident and had lost her medication. Nonetheless, respondent continued to prescribe opioids to Patient CB.

6. From time to time, respondent prescribed new opioids and/or increased the dosage or potency of currently prescribed opioids to Patient CB. At all times, respondent recorded the following substance abuse history for Patient CB.

Smoking Status:	Never Smoker
Smokeless tobacco:	Not on file
Alcohol Use:	No

7. However, on June 11, 2013, respondent took a detailed substance abuse history, including documentation of Patient CB's current analgesic regimen and potential side effects, activities of daily living, with 17 areas of inquiry. Also on June 11, 2013, respondent had Patient CB sign a "Pain Contract for Chronic Controlled Substance Treatment," documenting informed consent for treatment of pain management with controlled substances.

PATIENT MJ

8. To evaluate respondent's documentation, a review was made of Patient MJ's medical records, from January 1, 2012, to July 30, 2014. Patient MJ was seen by respondent for chronic pain management. Respondent prescribed opioids to Patient MJ, beginning on February 16, 2012. The medical records fail to document any informed consent discussions between respondent and Patient MJ, regarding the risks and benefits of taking opioid medication. On at least one occasion, Patient MJ exhibited notable behavior for a patient prescribed opioids; by meeting with respondent and asking him to continue to treat her son, even though respondent had terminated her son's care because he was seeking opioid

prescriptions from multiple doctors. Nonetheless, respondent continued to prescribe opioids to Patient MJ.

9. From time to time, respondent prescribed new opioids and/or increased the dosage or potency of currently prescribed opioids to Patient MJ. On numerous occasions, respondent failed to document any substance abuse history for Patient MJ. When taken, respondent recorded the following substance abuse history.

Smoking Status:	Current Everyday Smoker - 0.25packs/day
Smokeless tobacco:	Never Used
Alcohol Use:	Not of file

10. On October 4, 2012, respondent had Patient MJ sign a "Pain Contract for Chronic Controlled Substance Treatment," containing informed consent for treatment of pain management with controlled substances. On July 9, 2014, respondent had Patient MJ sign a new "Pain Contract for Chronic Controlled Substance Treatment," documenting informed consent for treatment of pain management with new controlled substances.

PATIENT KL

11. To evaluate respondent's documentation, a review was made of Patient KL's medical records, from January 1, 2013, to June 30, 2014. Patient KL was seen by respondent for chronic pain management. Respondent prescribed opioids to Patient KL, beginning on November 3, 2013. From time to time, respondent prescribed new opioids and/or increased the dosage or potency of currently prescribed opioids to Patient KL. At all times, respondent recorded the following substance abuse history for Patient KL.

Smoking Status:	Never Smoker
Smokeless tobacco:	Never Used
Alcohol Use:	0.5 oz/week

1 drink (s) per week

Comment: very rarely

PATIENT CG

12. To evaluate respondent's documentation, a review was made of Patient CG's medical records, from January 5, 2012, to February 27, 2015. Patient CG was seen by respondent for chronic pain management. Respondent prescribed opioids to Patient CG, beginning on February 7, 2012. The medical records fail to document any informed consent discussions between respondent and Patient CG regarding the risks and benefits of taking opioid medication. At times, Patient CG exhibited notable behavior for a patient prescribed opioids. For example, in May 2012, Patient CG reported the current dosage of Oxycontin was not effective in controlling her pain; and in October 2012, Patient CG admitted taking more Oxycodone than prescribed (i.e., one 80 mg tablet every four hours rather than one 80

mg tablet every six hours). Nonetheless, respondent continued to prescribe opioids to Patient CG.

13. From time to time, respondent prescribed new opioids and/or increased the dosage or potency of currently prescribed opioids to Patient CG. At all times, respondent recorded the following substance abuse history[2] for Patient CG.

Smoking Status:	Never Smoker
Smokeless tobacco:	Never Used
Alcohol Use:	No

14. However, on February 4, 2014, respondent took a detailed substance abuse history, including documentation of Patient CG's current analgesic regimen and potential side effects, activities of daily living, with 17 areas of inquiry. In addition, on May 9, 2014, respondent had Patient CG sign a "Pain Contract for Chronic Controlled Substance Treatment," documenting informed consent for treatment of pain management with controlled substances.

Medical Evidence

BOARD GUIDELINES

15. In 2007, the Board issued a Policy and Guidelines for Prescribing Controlled Substances for Pain (2007 Guidelines). The 2007 Guidelines begin with a preamble, identifying the Board's prior efforts and policy position on the topic of prescribing controlled substances for pain.

> In 1994, the Medical Board of California formally adopted a policy statement titled, "Prescribing Controlled Substances for Pain." The statement outlined the board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions. California physicians and surgeons are encouraged to consult this policy statement and guidelines below.
>
> In May 2002, as a result of AB 487, a task force was established to review the 1994 Guidelines and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and over

[2] On December 19, 2013, respondent also asked about drug use, with a negative response from Patient CG.

> medication of a patient's pain." The task force expanded the scope of the Guidelines from intractable pain patients to all patients with pain.
>
> [¶] . . . [¶]
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> Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs. The Medical Board recognized that some physicians do not treat pain appropriately due to a lack of knowledge or concern about pain, and others may fail to treat pain properly due to fear of discipline by the board. These Guidelines are intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the Medical Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. These Guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

16. The 2007 Guidelines outline six topic areas: History/Physical Examination, Treatment Plan, Objectives, Informed Consent, Period Review, Consultation, and Records. Under History/Physical Examination, the 2007 Guidelines state:

> A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

Under Informed Consent, the 2007 Guidelines read: "The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian." The annotation states, in part: "A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent." Under Records, the 2007 Guidelines provide: "The physician and surgeon should keep accurate records and complete records according to the items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the

treatment plan." Also in 2007, the Board required all licensed physicians and surgeons to take 12 hours of continuing medical education (CME) in prescribing chronic pain medications.

AMERICAN ACADEMY OF FAMILY PRACTICE GUIDELINES

17. On December 1, 2009, the American Academy of Family Physicians (AAFP) published Guidelines for the Use of Opioid Therapy in Patients with Chronic Noncancer Pain (AAFP Guidelines). The AAFP made "recommendations" in the following areas: patient selection and risk stratification, informed consent and opioid management plans, initiation and titration of therapy, methadone, monitoring, high-risk patients, higher dosages and discontinuation of therapy, adverse effects, pychotherapeutic cointerventions, opioid-related cognitive impairment, medical home and consultation, and breakthrough pain. Under patient selection and risk stratification, the AAFP Guidelines state:

> A history, physical examination and appropriate testing should be performed before the initiation of therapy, benefits versus risks should be assessed before and during therapy. A trial opioid therapy may be considered if pain is moderate or severe and the affects the patient's quality of life, and if potential therapeutic benefits are likely to outweigh potential harms.

The AAFP Guidelines were published in the Journal of Pain in February 2009.

BOARD EXPERTS

Christopher Chisholm, M.D., Pain Specialist

18. Dr. Chisholm completed his Bachelor of Arts in psychology in 1996 at Rutgers University in New Brunswick, New Jersey, before earning his Medical Degree in 2000, from the University of Medicine and Dentistry, New Jersey (UMDNJ), in Newark. Dr. Chisholm then completed a one-year internship in internal medicine at the UMDNJ Medical School, a three-year residency in anesthesiology at Presbyterian Medical Center, New York, and a one-year fellowship in anesthesiology and pain management at the UC Davis Medical Center. In 2004, he became licensed to practice medicine in California. Currently, Dr. Chisholm works in private practice for Comprehensive Pain Management Specialists in La Jolla, California. He has testified before and has been retained as an expert in pain management in civil matters for both plaintiff and defense.

19. The Board retained Dr. Chisholm to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care when he treated Patients CB, MJ, KL, and CG. The Board provided Dr. Chisholm with the following documents for his review: medical records for Patients CB, MJ, KL, and CG;

Controlled Substance Utilization, Review and Evaluation System (CURES) reports[3] for Patients CB, MJ, KL, and CG; certified patient pharmacy profiles for Patients CB, MJ, KL, and CG; pain contracts and drug testing laboratory reports for Patients CB, MJ, KL, and CG; respondent's curriculum vitae; respondent's Board interview transcript; and the Board Investigative Report. On January 9, 2016, Dr. Chisholm issued a Report. Dr. Chisholm testified at hearing consistent with his Report.

20. Dr. Chisholm identified the 2007 Guidelines as mirroring the standard of care for 2012, 2013, and 2014, requiring a substance abuse history and informed consent to be obtained and documented prior to the initiation of opiate therapy. Overall, Dr. Chisholm found respondent's substance abuse histories to be incomplete, and therefore, below the standard of care. The EPIC EMR prepopulated three questions under Substance Use Topics: smoking status, smokeless tobacco, and alcohol use. For the most part, respondent would complete the three questions, but sometimes, even those questions were left unanswered by respondent. While a substance abuse history should include questions about smoking status, smokeless tobacco, and alcohol use, a substance abuse history should also include the following type questions: has the patient used/abused illegal drugs; is there a family history of drug or alcohol use/abuse; has the patient been involved in car or other accidents; has the patient requested early opioid refills; has the patient increased opioid doses without authorization from the doctor; has the patient reported lost or stolen prescriptions; has the patient attempted to obtain prescriptions from other clinicians; has the patient used pain medication in response to situational stressors; does the patient insist upon certain medications, by name; has the patient had contact with street drug culture; has the patient hoarded (i.e. stockpiled) medications; has the patient been arrested; been a victim of abuse; etc. Dr. Chisholm would require respondent to complete a substance abuse history each time he prescribed a new medication to a patient.

21. In addition, Dr. Chisholm found respondent's charts to lack documentation of informed consent discussions with his patients. Dr. Chisholm would require respondent to inform patients of the possible side effects of a prescribed opioid medication, including decreased respiration and death; and when opioids are prescribed in conjunction with benzodiazepines, muscle relaxers, and/or antidepressants, respondent must ensure the patient is informed of the multiplying effects and interactions of the medications taken together. Thereafter, a doctor must document in the patient's chart the informed consent discussion.

22. Focused on the four patients at issue, Dr. Chisholm found the following departures from the standard of care:

a. For Patient CB, Dr. Chisholm found respondent failed to document a substance abuse history or obtain informed consent prior to initiating opioid therapy, each constituting a simple departure from the standard of care.

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[3] A CURES Report shows all of the controlled substances prescribed and filled by an individual patient.

b. For Patient MJ, Dr. Chisholm found respondent failed to document a substance abuse history or obtain informed consent prior to initiating opioid therapy, each constituting a simple departure from the standard of care.

c. For Patient KL, Dr. Chisholm found respondent failed to document a substance abuse history prior to initiating opioid therapy, constituting a simple departure from the standard of care.

d. For Patient CG, Dr. Chisholm found respondent failed to document a substance abuse history or obtain informed consent prior to initiating opioid therapy, each constituting a simple departure from the standard of care.

23. Ultimately, Dr. Chisholm opined:

> Dr. Doan did provide care for [Patients CB, MJ, KL, and CG] in the form of pain management. During this time he prescribed opioid medications. Although I feel in some instances his dose of opiate medications may have been aggressive, I could only find simple departures from the standard of care in this case. Based on a review of his medical records, it does show a progression in understanding and a change in his practice as it relates to pain management. Dr. Doan began to titrate some of his patients off of opiate medications. In later visits, he instituted a formal opiate agreement and he did document attempts to reduce opiate dose. He did provide alternatives for the patients including the use of suboxone and seeing a pain management specialist. Dr. Doan did fail to document any history of substance abuse in his medical records. In my opinion this constitutes a simple departure from the standard of care.

Norman Bensky, M.D., Family Practice

24. Dr. Bensky completed his Bachelor of Science in biophysics in 1975 at Syracuse University, New York, before earning his Medical Degree in 1980, from George Washington University, Washington D.C. Dr. Bensky then completed a one-year internship in family practice at Bristol Memorial Hospital in Tennessee, and a two-year residency in family practice at University of Florida School of Medicine, Gainesville. In 1985, he became licensed to practice medicine in California. He is Board Certified by the American Board of Family Practice. Currently, Dr. Bensky is a Clinical Assistant Professor of family practice and a Physician Assistant Preceptor at the UC Davis School of Medicine in Sacramento; an emergency room physician at Redwood Memorial Hospital in Fortuna, California; and the Medical Director at the Willow Creek Family Health Center. He has hospital privileges at Redwood Memorial and St. Joseph in Eureka. He has reviewed Board cases for more than 20 years and written

reports, testifying in only one other Board matter. He has testified and been retained as an expert in civil matters for plaintiff and defense.

25. The Board retained Dr. Bensky to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care for a family practice doctor when he treated Patients CB, MJ, KL, and CG. The Board provided Dr. Bensky with the following documents for his review: medical records for Patients CB, MJ, KL, and CG; CURES reports for Patients CB, MJ, KL, and CG; certified patient pharmacy profiles for Patients CB, MJ, KL, and CG; pain contracts and drug testing laboratory reports for Patients CB, MJ, KL, and CG; respondent's curriculum vitae; respondent's Board interview transcript; and the Board Investigative Report. On October 11, 2015, Dr. Bensky issued a Report. Dr. Bensky testified at hearing consistent with his Report.

26. Dr. Bensky also identified the 2007 Guidelines as mirroring the standard of care, requiring a substance abuse history and informed consent to be obtained and documented prior to the initiation of opiate therapy. Overall, Dr. Bensky found respondent's substance abuse histories to be incomplete, and therefore, below the standard of care. For Dr. Bensky, a substance abuse history is not complete after asking about smoking status, smokeless tobacco use, and alcohol use. For a complete substance abuse history, Dr. Bensky suggested using a screening tool/questionnaire to gain information from patients, and then identified the necessary follow-up areas of inquiry. At a minimum, a substance abuse history should include questions about: previous narcotics use/abuse, drug use/abuse, alcohol use/abuse, family history of alcohol and drug use/abuse, and diagnosed psychiatric conditions.

27. Focused on the four patients at issue, Dr. Bensky found the following departures from the standard of care:

a. For Patient CB, Dr. Bensky found respondent failed to document a history and physical, including a substance abuse history, or obtain informed consent prior to initiating opioid therapy, each constituting an extreme departure from the standard of care.

b. For Patient MJ, Dr. Bensky found respondent failed to document a history and physical, including a substance abuse history, an extreme departure from the standard of care, or obtain informed consent prior to initiating opioid therapy, a simple departure from the standard of care.

c. For Patient KL, Dr. Bensky found respondent failed to document a history and physical, including a substance abuse history, prior to initiating opioid therapy, constituting an extreme departure from the standard of care.

d. For Patient CG, Dr. Bensky found respondent failed to document a history and physical, including a substance abuse history, or obtain

informed consent prior to initiating opioid therapy, each constituting an extreme departure from the standard of care.

RESPONDENT'S EXPERT – LEE THOMAS SNOOK, JR., M.D., PAIN SPECIALIST

28. Dr. Snook earned a Bachelor of Science in chemistry in 1976, and his Medical Degree in 1980, at the University of Nevada, Reno. Dr. Snook then completed a two-year internship in internal medicine and a one-year residency in anesthesiology at the University of Wisconsin Hospital and clinics, in Madison. In 1984, he became licensed to practice medicine in California. He is a Diplomate of the American Board of Anesthesiology, Internal Medicine, Medical Examiners, Pain Medicine, and a Fellow of the American Society of Addiction Medicine. He has been a Qualified Medical Examiner since 1995. Dr. Snook has worked as an emergency room physician at St. Clair Hospital and Beaver Dam Community Hospital in Wisconsin, an Assistant Clinical Professor of Anesthesiology for UC Davis Medical Center, and Medical Director for Mercy Healthcare Sacramento. In 1992, Dr. Snook founded Metropolitan Pain Management Consultants, a medical group in Sacramento, where he practices to date. And in 1998, Dr. Snook also founded the Metropolitan Anesthesiology Consultants, a medical group in Sacramento, where he practices to date. He has hospital privileges at Sutter Roseville, Sutter Medical Center, Mercy San Juan, Mercy General, and Mercy Folsom. Dr. Snook has testified and been retained as an expert in many medical cases.

29. Respondent retained Dr. Snook to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care when he treated Patients CB, MJ, KL, and CG. Dr. Snook reviewed the following documents prior to his testimony: previous Board actions he was involved in on similar issues; the Center for Disease Control Guidelines for Prescribing Opioids for Chronic Pain; the 2007 Guidelines; the 2014 Board Guidelines for Prescribing Controlled Substances for Pain; the Accusation; the medical records for Patients CB, MJ, KL, and CG; the Report by Dr. Chisholm; and the Report by Dr. Bensky.

30. Dr. Snook does not consider the 2007 Guidelines to mirror the standard of care for a family practice doctor in prescribing controlled substances to a chronic pain patient. For Dr. Snook, the 2007 Guidelines are a tool to assist physicians, but not rules, mandates, or requirements to be followed without deviation. He believes the 2007 Guidelines are a measurement or set of standards for the Board's Division of Medical Quality to use in evaluating physician conduct and determine when discipline is appropriate. Instead, Dr. Snook defines the standard of care for a family physician prescribing controlled substances to a chronic pain patient as "what the physician decides is best for a particular patient." He explained: the standard of care changes; it is contextual; based upon the full history of the patient; and the doctor-patient relationship; because the doctor has the best available knowledge to make a decision in the best interest of his/her patient.

31. In sum, Dr. Snook is offended by the allegations against respondent, a family practice doctor treating multiple difficult chronic pain patients. Dr. Snook believes the substance abuse history of a patient is a small part of managing chronic pain; the

requirements/components of a substance abuse history are poorly understood by the medical community; and the 2007 Guidelines provide no direction on what should be included in a substance abuse history. Nonetheless, when questioned, Dr. Snook acknowledged the 2007 Guidelines require a substance abuse history. As a pain management specialist, Dr. Snook uses a 16-page health history and pain questionnaire to obtain a substance abuse history from his patients. When concerns arise (e.g., the patient loses medications, gives excuses for needing early refills, a pharmacist is calling about the patient, CURES shows multiple prescribers, negative urine test results, etc.), Dr. Snook documents and reassesses the goals and objectives of the patient's opioid therapy.

32. Focused on the four patients at issue, Dr. Snook found no departures from the standard of care relative to respondent's treatment of Patients CB, MJ, KL, and CG. He looked at the comprehensive medical records and determined respondent made no deviation from the standard of care.

RESPONDENT

33. Respondent earned a Bachelor of Science in chemistry and health science and medical technology from University of Florida, in Gainsville, in 1983, before completing his Medical Degree at Ohio State University in 1991. Respondent then completed a three-year internship/residency in family practice at David Grant Medical Center, Travis Air Force Base, Fairfield, California. In 1993, respondent became licensed to practice medicine in California. He is Board Certified by the American Board of Family Medicine. From 1994 to 1998, respondent was an officer with the Air Force, serving as a Staff Physician in Izmir, Turkey, and Sacramento, California. From 1998 to 2014, respondent was a family practice doctor for Sutter in Rocklin, California. Also in 1998, respondent began working as a clinical professor at the University of California, Davis Medical School, and remains in that role today. In 2014, respondent was terminated by Sutter. Shortly thereafter, he found work at Med 7 Urgent Care clinics in Roseville, Carmichael, Natomas, and Folsom, and then in 2015, respondent began a private practice in family medicine in Rocklin. He continues at Med 7 and in private practice to date.

34. Respondent is an immigrant. He came to the United States at age 14, escaping Vietnam after the war. He and his family were placed in Florida. He was one of two Vietnamese immigrants at his high school. He learned to speak English, went to school, and worked at a gasoline and bait and tackle shop and McDonald's to help support his family. He went to college in Florida, graduated, and moved to Ohio. He took graduate classes, and then applied and was accepted into medical school. Respondent knew medicine was his calling because he wanted to help others. In need of help paying for medical school, respondent spent time in the military, treating military personnel and their families. After the military, respondent was hired by Sutter.

35. At Sutter, respondent used the EPIC system to document patient encounters. When respondent created a new chart note, EPIC prepopulated several topic areas, including: Past Medical History, Diagnosis; Past Surgical History, Procedure; Patient Active Problem

List; History, Substance Use Topics, smoking status, smokeless tobacco, and alcohol use; Family History, Problem; Obstetric History; Current Outpatient Prescriptions; Physical Examination; and Assessment/Plan. Respondent made every effort to complete the prepopulated areas in EPIC for each patient visit. However, in 2014, Sutter asked respondent to make changes to his chronic pain patient care, including better medical recordkeeping, use of and adherence to pain contracts and drug screening results, timely follow-up appointments, and less opioid prescribing. Respondent attempted to change his practices, but found the process to be untenable because of the sheer volume of patients. Respondent believes Sutter should have helped him succeed in making the necessary changes and they did not. Instead, Sutter fired him. While working for Sutter, respondent participated in group meetings, workshops with speakers, and chart reviews for the quality assurance committee, and respondent does not remember a single topic on substance abuse histories, informed consent, or prescribing opioids and chronic conditions.

36. Respondent considers himself a physician and friend to his patients. For chronic pain patients, respondent felt both empathetic and sympathetic and often helpless in providing his patients pain relief. Respondent knew Patients CB, MJ, KL, and CG quite well; he saw them frequently and was their primary care physician for many years. Respondent made care and treatment decisions for Patients CB, MJ, KL, and CG, based upon his extensive knowledge of their medical histories.

37. When questioned, respondent acknowledged his documentation might have been lacking for Patients CB, MJ, KL, and CG. He admitted that without greater documentation, another physician reviewing the medical file and considering treatment options for Patients CB, MJ, KL, and CG, would not know respondent's rationale for prescribing controlled substances or whether a patient's failure to comply with a pain contract was a sign of opioid abuse. Respondent admitted he was unfamiliar with the Board's 2007 Guidelines in 2012, 2013, and 2014, when he was treating Patients CB, MJ, KL, and CG. He was unaware the 2007 Guidelines required a substance abuse history and informed consent, with supporting documentation in the medical file, before the initiation of opioid therapy. He does remember the Board requiring physicians to take 12 hours of CME in prescribing controlled substances for pain in or around 2007. Even still, respondent did not view the Board's 2007 Guidelines as rules he was required to follow; but rather, respondent saw the 2007 Guidelines as a resource for physicians, providing suggestions for practice. Using the 2007 Guidelines as the standard of care, respondent acknowledged his medical file documentation was below the standard of care for Patients CB, MJ, KL, and CG. Respondent also admitted he was unaware the FFAP issued guidelines in 2009 regarding the use of opioid therapy in patients with chronic noncancer pain, and acknowledged the FFAP Guidelines are very similar to the Board's 2007 Guidelines.

38. Respondent is willing to learn and change his practice. On April 22, 2017, respondent took a physician/patient communication class, and on April 27, 2017, respondent took a medical record-keeping class (3 days) and a prescribing pain medications class (3 days) at Physician Assessment and Clinical Education program (PACE) in San Diego. In the medical recordkeeping class, respondent learned he must complete and document informed

consent discussions, which can be done in a pain contract; a risks/benefits assessment; and a substance abuse history. Respondent took the PACE classes in 2017 at the recommendation of his attorney. Prior to 2017, respondent indicated he was unaware of PACE or that courses in medical record keeping and prescribing pain medications existed. Respondent has already enrolled in additional CME.

Character Testimony

39. Patients CB, MJ, and KL testified on behalf of respondent. Patient CG passed away on March 20, 2015; her husband, SG, testified on respondent's behalf. Each witness expressed thanks and praise for respondent's personalized care and treatment. Each witness found respondent to be empathetic and sympathetic and personally invested in their health. To that end, Patient CB followed respondent to his private practice and remains a patient to date.

Discussion

40. This is a documentation case. The question is whether, for Patients CB, MJ, KL, and CG, respondent documented a substance abuse history and informed consent discussion sufficient to meet the standard of care in 2012, 2013, and 2014. The Board called Drs. Chisholm and Bensky, who both found respondent failed to meet the standard of care for all patients. Respondent called Dr. Snook, who found respondent met the standard of care for all patients.

41. Drs. Bensky and Chisholm found the standard of care to include a detailed substance abuse history and documentation of an informed consent discussion prior to the initiation of opioid therapy, as indicated in the 2007 Guidelines. Dr. Snook found the standard of care to be whatever a doctor believes is appropriate for the patient, and dismissed the 2007 Guidelines as mere suggestions. Dr. Snook's definition of the standard of care for a family practice doctor is illogical and tautological and his opinions on the 2007 Guidelines are difficult to fathom, especially when the Board is charged with protecting the public from doctors who are practicing below the standard of care and/or are dangerous to the public.

42. Interestingly, Dr. Snook, a pain specialist, has his patients complete an extensive questionnaire before treatment; a survey, asking questions Drs. Chisholm and Bensky identify as necessary for a complete substance abuse history. Nonetheless, Dr. Snook separates himself from respondent, because he is a pain specialist and respondent is a family practice doctor; and noted a family practice doctor cannot be held to the same standard as a pain specialist. That said, Dr. Snook acknowledged respondent was treating four very difficult chronic pain patients. Logically then, if respondent was treating four very difficult chronic pain patients, and not referring them out for management by a pain specialist, then respondent was required to meet the standard of care of a pain specialist.

43. Dr. Chisholm, a pain specialist, offered a reasonable and logical interpretation of the standard of care, relying on the 2007 Guidelines, and a reasonable evaluation of

respondent's chart documentation; respondent made a series of simple departures from the standard of care when documenting substance abuse histories and informed consent discussion for Patients CB, MJ, KL, and CG. All three doctors agreed on the necessity for a detailed substance abuse history and/or risk stratification of chronic pain patients being treated with opioid medications, and the need to explain to patients the risks and benefits of opioid medication, including death, and then document that discussion in the medical chart. All three doctors treat chronic pain patients with opioids. Given the above, respondent did not meet the standard of care for a pain specialist, or a family care doctor, because he failed to take detailed substance abuse histories from Patients CB, MJ, KL, and CG and document informed consent discussions with Patients CB, MJ, and CG; and as a result, respondent made seven simple departures from the standard of care.

44. At hearing, respondent acknowledged his scant charting on substance abuse histories and informed consent discussions, but he expressed a sincere desire to make changes to his practice and comply with the standard of care. Since the instant Accusation, he has attended a medical recordkeeping class and a prescribing pain medications class, as well as having completed PACE; but admitted he attended the classes only after his attorney directed him to do so. In addition, respondent has already been offered the opportunity to change his practice, when Sutter met with him, first on May 3, 2013, and again, and again, until Sutter terminated him on July 16, 2014, because respondent failed to use the 14 months to improve his charting and his care of chronic pain patients.

45. Nonetheless, respondent has attended relevant classes and he has begun to change his prescribing practice, as noted by Dr. Chisholm. However, he does not appear to be self-motivated to seek out coursework to improve his practice, nor does he appear to be motivated by consequences, including the loss of employment, because respondent failed to make changes to his practice when Sutter asked him to do so. Going forward, respondent must continue to improve, and consistently take substance abuse histories and document informed consent discussions with his chronic care patients. At this time, the Board has no assurances respondent will make changes to his practice, on his own; and he is practicing in a private setting. To ensure respondent makes such changes, and consistent with public protection, he must be shepherded for a period of time by placing him on Board probation.

LEGAL CONCLUSIONS

Standard of Proof

1. To revoke or suspend respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently

strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Laws

2. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes, but is not limited to: repeated negligent acts." (Bus. & Prof. Code, § 2234, subd. (c).) "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." (Bus. & Prof. Code, § 2234, subd. (c).)

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

Cause for Discipline

4. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in repeatedly negligent acts in his care and treatment of Patients CB, MJ, KL, and CG.

5. Cause exists for disciplinary action under Business and Professions Code section 2266, by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent failed to maintain adequate and accurate records relating to the provision of services to Patients CB, MJ, KL, and CG.

6. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions constitute cause for discipline. However, respondent seems willing to change his practice and appears to be a good candidate for probation. With monitoring and guidance, respondent can provide medical care to patients without harm to the public.

ORDER

Physician's and Surgeon's Certificate No. G 77825 issued to respondent Tuan Anh Doan, M.D. is REVOKED. However, the revocation is STAYED, and respondent is placed on probation for two years upon the following terms and conditions:

1. **Education Course**

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

2. **Monitoring - Practice**

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

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

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

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

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

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

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

3. **Solo Practice Prohibition**

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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 not resume practice until an appropriate practice setting is established.

4. **Notification**

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

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

5. **Supervision of Physician Assistants and Advanced Practice Nurses**

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

6. **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.

7. **Quarterly Declarations**

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

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

8. **Compliance with Probation Unit**

Respondent shall comply with the Board's probation unit.

9. **Address Changes**

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

10. **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.

11. **License Renewal**

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

12. **Travel or Residence Outside California**

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

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

13. **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.

14. **Non-practice While on Probation**

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

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

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

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

15. **Completion of Probation**

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

16. **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.

17. **License Surrender**

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

18. **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.

DATED: November 13, 2017

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ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Aug 5 2016
BY _____ ANALYST

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

In the Matter of the Accusation Against: **Tuan Anh Doan, M.D.** 1230 Sunset Blvd, Ste 400 Rocklin, CA 95765 Physician's and Surgeon's Certificate No. G 77825, Respondent.	Case No. 800-2014-007305 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 27, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G 77825 to Tuan Anh Doan, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

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JURISDICTION

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

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

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

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

"(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.

"...

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

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

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

"..."

6. Section 2266 of the Code, states:

"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."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the treatment of four patients. The circumstances are as follows:

Patient C.B.

8. Respondent provided patient C.B. with long term pain management care. A review of Respondent's care was undertaken by reviewing C.B.'s medical records dated January 1, 2012, to July 30, 2014. Between January 1, 2012, and May 6, 2013, Patient C.B. had 9 treatment visits with Respondent.[1] On October 1, 2012, patient C.B. requested a refill of her Morphine Sulfate ER[2] tablets despite having previously received a three month supply on July 30, 2012 which should have lasted her until October 30, 2012. Patient C.B. stated that she was out of medication when requesting a refill. On October 31, 2012, patient C.B. requested Respondent refill her prescription for Hydrocodone/Acetaminophen[3] despite having just refilled her medication two weeks earlier. Patient C.B. claimed that she had been in a motor vehicle accident and had lost her prescription. Despite patient C.B. running out of medication and losing her medication between January 1, 2012, and May 6, 2013, Respondent failed to document that he reviewed, and/or solicited patient C.B.'s substance abuse history in the medical records.

9. According to Respondent's medical records of the care he rendered to patient C.B., informed consent was obtained on June 11, 2013. The informed consent was documented in a "Pain Contract for Chronic Controlled Substance Treatment." Respondent prescribed controlled substances to C.B. before informed consent was obtained and/or documented. The records do not

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[1] On June 2, 2014, Respondent evaluated C.B.'s substance abuse history.

[2] Morphine Sulfate ER ("MS Contin") is a long acting narcotic analgesic used in the treatment of chronic pain. It is classified as a Schedule II controlled substance.

[3] Acetaminophen with Hydrocodone ("Norco") is a short acting combination medication comprised of a narcotic pain reliever and acetaminophen used to alleviate moderate to severe pain. It previously was listed as a Schedule III controlled substance until October 6, 2014, when it was rescheduled as a Schedule II controlled substance.

contain any other documentation that indicates that the risks and benefits of opiate therapy were discussed prior to the initiation of treatment.

Patient M.J.

10. Respondent provided patient M.J. with long term pain management care. A review of Respondent's care was undertaken by reviewing M.J.'s medical records dated January 1, 2012, to July 30, 2014. On January 30, 2012, Respondent noted that he spent more than twenty minutes with the patient educating and counseling her regarding pain management. The note does not contain a substance abuse history evaluation. On February 29, 2012, M.J. was initially evaluated by a pain management practice and a substance abuse history evaluation was completed by a separate pain management physician. Respondent next saw patient M.J. on March 30, 2013. No substance abuse history was reviewed, solicited, and/or documented despite Respondent prescribing controlled substances to M.J.[4] On June 17, 2013, M.J. met with Respondent on behalf of her son who had been terminated from Respondent's practice for "Doctor Shopping" for opioid medications. No substance abuse history was conducted for M.J. On September 11, 2013, Respondent met M.J. in clinic and no substance abuse history was reviewed, solicited, and/or documented. On October 22, 2013, Respondent met with M.J. in clinic for medication refills and no substance abuse history was reviewed, solicited and/or documented.

11. On January 13, 2014, Respondent met with M.J. and noted that she could not get a pain management consultation due to insurance issues. Respondent added Morphine Sulfate to M.J.'s medications. Respondent did not review and/or document a substance abuse history when titrating a new medication. On March 20, 2014, Respondent met with M.J. for a follow-up appointment. Respondent did not review and/or document a substance abuse history.

12. Respondent provided patient M.J. with long term pain management care. During a review of the records, informed consent was obtained and documented on October 4, 2012. Respondent prescribed controlled substances to M.J. before informed consent was obtained. The

[4] Respondent was prescribing Oxycodone with Acetaminophen ("Percocet") at this time. Oxycodone is an opioid pain medication used for the relief of moderate to severe pain. It is classified as a Schedule II controlled substance.

records do not contain any other documentation that indicates that the risks and benefits of opiate therapy were discussed prior to the initiation of treatment. Despite adding a prescription for Morphine Sulfate to M.J.'s prescribed medications on January 13, 2014, and continuing the prescription for Morphine Sulfate on March 20, 2014, and April 2, 2014, Respondent did not obtain and/or document a new pain contract and informed consent with Morphine Sulfate listed as a prescribed medication until July 9, 2014.

Patient K.L.

13. Respondent provided patient K.L. with long term pain management care. A review of Respondent's care was undertaken by reviewing K.L.'s medical records dated January 1, 2013, to June 30, 2014. Respondent provided care to K.L. at six appointments during that time period. Respondent did not review or reassess K.L.'s substance abuse history during any of the six appointments.

Patient C.G.

14. Respondent provided patient C.G. with long term pain management care. A review of Respondent's care was undertaken by reviewing C.G.'s medical records from January 5, 2012, to February 27, 2015. On February 17, 2012, Respondent was prescribing 240 tablets of 10 mg Oxycodone HCL[5] and 240 tablets of 80 mg Oxycodone-ER per month. Between February 17, 2012, and May 23, 2012, Respondent saw C.G. on four separate occasions. He did not review, solicit, and/or document a substance abuse history.

15. On May 23, 2012, Respondent noted that the current dosage of "Oxycontin" was not effective to control C.G.'s pain. On May 23, 2012, Respondent prescribed 60 tablets of 40 mg Oxymorphone HCL[6] and 240 tablets of 15 mg Oxycodone. Respondent did not review, solicit, and/or document C.G.'s substance abuse history when titrating a new medication. Between June 15, 2012, and October 29, 2012, Respondent saw C.G. on four separate occasions. On October

[5] Respondent was prescribing Oxycodone HCL and Oxycodone-Extended Release ("Oxycodone") at this time. Oxycodone is an opioid pain medication used for the relief of moderate to severe pain. It is classified as a Schedule II controlled substance.

[6] Respondent was prescribing Oxymorphone –ER ("Opana") at this time. Oxymorphone is a powerful semi-synthetic opioid analgesic used for the relief of severe pain. It is classified as a Schedule II controlled substance.

29, 2012, Respondent noted that C.G. was taking an 80 mg tablet of oxycodone every four hours rather than every six hours as prescribed. Respondent failed to review, solicit, and/or document a substance abuse history between June 15, 2012, and October 29, 2012.

16. On January 14, 2013, Respondent noted that C.G. was now receiving 180 tablets of 30 mg Oxycodone and 480 tablets of 80 mg Oxycodone-ER per month. Despite the increase in controlled substances, no substance abuse history was reviewed, solicited, and/or documented by Respondent. Respondent did not review, solicit, and/or document a substance abuse history between March 10, 2013, and, June 3, 2013, despite seeing C.G. five times in office. It is also noteworthy that Respondent increased C.G.'s "Oxycontin" prescription on May 21, 2013, without performing a substance abuse history. Between July 8, 2013, and, January 13, 2014, Respondent saw C.G. on four occasions for follow-up care and did not perform a substance abuse history. On February 4, 2014, Respondent finally performed a substance abuse history and documented her substance abuse history in the medical record.

17. According to Respondent's medical records of the care he rendered to patient C.G., informed consent was obtained on May 9, 2013. The informed consent was documented in a "Pain Contract for Chronic Controlled Substance Treatment." Respondent prescribed controlled substances to C.G. before informed consent was obtained. The records do not contain any other documentation that indicates that the risks and benefits of opiate therapy were discussed prior to the initiation of treatment.

18. Respondent's actions represented repeated negligent acts for the following reasons:

1. Failure to periodically review and document patient C.B.'s substance abuse history in the medical records between January 1, 2012, and May 6, 2013, was a departure from the standard of care;

2. Failure to obtain informed consent from patient C.B. prior to the initiation of opioid therapy was a departure from the standard of care;

3. Failure to periodically review and document patient M.J.'s substance abuse history in the medical records between March 30, 2013, and March 20, 2014, was a departure from the standard of care;

4. Failure to obtain informed consent from patient M.J. prior to the initiation of opioid therapy was a departure from the standard of care;

5. Failure to periodically review and document patient K.L.'s substance abuse history in the medical records between January 1, 2013, and June 30, 2014, was a departure from the standard of care;

6. Failure to periodically review and document patient C.G.'s substance abuse history in the medical records between February 17, 2012, and February 4, 2014, was a departure from the standard of care;

7. Failure to obtain informed consent from patient C.G. prior to the initiation of opioid therapy was a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

19. Respondent's license is subject to disciplinary action under section 2266, in that the records of his care and treatment of four patients were either inaccurate, inadequate or both. The circumstances are as follows:

20. The allegations of paragraphs 8 to 18 above are incorporated herein by reference.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 77825, issued to Tuan Anh Doan, M.D.;

2. Revoking, suspending or denying approval of Tuan Anh Doan, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Tuan Anh Doan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 5, 2016

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

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