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

In the Matter of the Accusation Against:	)	
William C. Hopkins, M.D.	)	**Case No. 800-2017-029042**
Physician's and Surgeon's Certificate No. A24984	)	
Respondent	)	

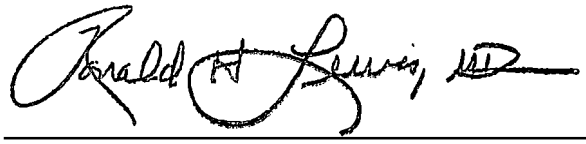
DECISION

The attached Stiplulated 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 March 13, 2020.

IT IS SO ORDERED: February 13, 2020.

MEDICAL BOARD OF CALIFORNIA



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

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **WILLIAM C. HOPKINS, M.D.** 3803 S. Bascom #210 Campbell, CA 95008 **Physician's and Surgeon's Certificate No. A 24984** Respondent.	Case No. 800-2017-029042 OAH No. 2019070439 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). Former Executive Director Kimberly Kirchmeyer brought this action solely in her official capacity of Executive Director of the Board.[1] Christine Lally is

[1] Kimberly Kirchmeyer became Director of the California Department of Consumer Affairs, effective October 28, 2019.

represented in this matter by Xavier Becerra, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

2. Respondent William C. Hopkins, M.D. (Respondent) is represented in this proceeding by attorney Thomas E. Still Esq., whose address is: 12901 Saratoga Avenue, Saratoga, CA 95070-9988.

3. On or about September 18, 1972, the Board issued Physician's and Surgeon's Certificate No. A 24984 to William C. Hopkins, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-029042, and will expire on July 31, 2021, unless renewed.

JURISDICTION

Accusation No. 800-2017-029042 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 9, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2017-029042 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-029042. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-029042, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

10. 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 Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2017-029042 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.

11. 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

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or 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.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 24984 issued to Respondent William C. Hopkins, 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 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, including the prescribing of controlled substances, and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course

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 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course 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 15 calendar days after successfully completing the course, or not later than

15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

7. 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.

8. 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.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

10. 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.

11. 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 Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

12. 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.

13. 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.

14. 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.

15. 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.

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ACCEPTANCE

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

DATED: 12/23/2019

WILLIAM C. HOPKINS, M.D.
Respondent

I have read and fully discussed with Respondent William C. Hopkins, 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: 12/23/2019

THOMAS E. STILL ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/23/19

Respectfully submitted,

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

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO May 9 2019
BY K. Vuong ANALYST

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

In the Matter of the Accusation Against: **William C. Hopkins, M.D.** 3803 S. Bascom #210 Campbell, CA 95008 **Physician's and Surgeon's Certificate No. A 24984,** Respondent.	Case No. 800-2017-029042 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about September 18, 1972, the Medical Board issued Physician's and Surgeon's Certificate No. A 24984 to William C. Hopkins, 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 July 31, 2019, unless renewed.

JURISDICTION

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

4. 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."

5. 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:

". . .

"(b) Gross negligence.

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

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

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

". . . ."

6. Section 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."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

9. **Ativan,** the trade name for lorazepam, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures.

10. **Diazepam,** known by the trade name Valium, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon

abrupt discontinuance. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

11. **Dilaudid** is a trade name for hydromorphone hydrochloride. It is a dangerous drug as defined in Business and Professions Code section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b). It is primarily used as a pain reliever. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

12. **Fentanyl** (Actiq, Fentora, and Duragesic) is powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication ordinarily used to treat patients with severe pain, especially after surgery. When properly prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant patients, severe enough to require daily, continuous, long term opioid treatment, and for which alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. The FDA has issued several black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

Fentanyl comes in several forms, including as an injection, intrathecal administration (an injection around the spinal canal), a transdermal patch that is placed on the skin, or as a lozenge that is sucked like a cough drop (Actiq).

13. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

14. **Ketamine**, or ketamine hydrochloride, is a non-barbiturate, rapid-acting injectable anesthetic. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code.

15. **MS Contin** (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified MS Contin, as a drug of abuse. (Drugs of

Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin with benzodiazepines or other central nervous system (CNS) depressants.

16. **Oxycodone** (Percocet), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

17. **Soma**, a trade name for carisoprodol tablets, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It can be habit forming and its side effects may impair thinking or reactions; it can increase dizziness and drowsiness.

18. **Sufentanil**, sold under the brand names Dsuvia and Sufenta, is a synthetic opioid analgesic drug approximately 5 to 10 times more potent than its parent drug, fentanyl, and 500 times as potent as morphine. Sufentanil is used to relieve pain during and after surgery or other medical procedures. Sufentanil is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. It has a high risk for addiction and dependence, and can lead to respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol.

19. **Temazepam** (Restoril), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Restoril with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Restoril, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

20. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

PATIENT A

22. Respondent first started treating Patient A,[1] a then-71-year old female, in approximately January 2009, for lower back pain.[2] The patient was diagnosed with lumbar failed back syndrome.[3] Patient presented with a medication regimen of fentanyl transdermal patches, fentanyl pops (Actiq), Norco, and Soma. Respondent continued his care and treatment of Patient A and maintained her on this medication regimen. By approximately May 2012, Respondent continued to prescribe Actiq 200 mcg #45, once daily, Fentanyl patch 50 mcg #10, every 72

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[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] The prerequisite for a diagnosis of failed back syndrome is a prior spine surgery and persistent pain post-surgery, yet Patient A's past medical history denies any prior surgery.

hours, Soma 350mg #120, every six hours, Norco 10/325 mg #180, every four hours, and Lidoderm patch #60. In Patient A's progress note dated on or about February 12, 2013, the patient appeared to be in severe pain whether on or off opioid therapy and demonstrated signs of considerable dysfunction. Respondent noted his intent to "maintain the current medication regimen with efforts to decrease medication use." However, Respondent continued this medication regimen through 2017, with the exception of discontinuing Soma starting in 2017 and briefly tapering opioid therapy only to later escalate the dose.

23. On or about November 16, 2015, an intrathecal device[4] was initiated to target delivery of pain medication to treat Patient A's failed back syndrome. On or about December 15, 2015, Respondent increased the dose of Actiq 200 mcg from once daily to twice daily. Respondent did not document the rationale or treatment objective with the fentanyl dose escalation. Absent from progress notes dated on or about July 1, 2014, March 10, 2015, March 7, 2016, May 3, 2016, May 11, 2016, June 9, 2016, August 3, 2016, September 28, 2016, November 29, 2016, and June 7, 2017, are the following:

1) Risk-benefit analysis of opioid therapy;
2) Rationale for high dose opioid therapy;
3) Rationale for combining controlled substances that can increase the risk of unintentional overdose;
4) Treatment plan with objectives to be achieved with opioid therapy; and
5) The use of rapidly acting mucosal fentanyl therapy for non-malignant pain.

24. On or about August 2, 2017, Respondent noted that Patient A's chief complaint and primary diagnosis continued to be her lower back pain. It was also noted that the patient had ongoing lung carcinoma, yet the patient had been on constant opioid therapy prior to her malignancy. Patient A had been continually prescribed rapidly-released fentanyl pops (Actiq) to treat her lower back pain, despite such medication being intended to treat pain associated with malignancy. The patient was also continually prescribed 100 mcg of transdermal fentanyl, which

[4] An intrathecal device, or "pain pump," is a small pump surgically implanted under the skin of the abdomen that delivers medication through a catheter to the area around the spinal cord.

amounted to a 300 mg morphine equivalent. In conjunction with Norco 10/325 mg, five times per day, Patient A's morphine equivalent dose of medication was over 420 mg for the overall opioid regimen. Again, missing from this progress note was a specific treatment plan with specified objectives, an evaluation of the functional benefit and improvement on opioid therapy, whether the risk/benefit of the opioid therapy was discussed with the patient, and appropriate surveillance of prior drug screens.

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

(a) Respondent failed to document a defined risk benefit analysis regarding opioid therapy;

(b) Respondent failed to document an appropriate description regarding the rationale for high dose opioid therapy;

(c) Respondent failed to appropriately document the rationale for combining fentanyl with other controlled substances, such as Soma, that compound the risk of unintentional overdose;

(d) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(e) Respondent prescribed rapidly acting mucosal medication for non-malignant pain, specifically failed back syndrome;

(f) Respondent escalated the opioid dose with no rationale or adjustment in the treatment plan;

(g) Respondent did not take appropriate steps to ensure medication compliance, such as random urine screens, blood samples, or review of CURES; and

(h) Respondent continued to prescribe controlled substances despite poor results with the patient regarding pain and function.

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PATIENT B

26. In approximately 2007, Respondent began treating Patient B, a then-41-year old female, with a chief complaint of lower back pain and a medication regimen that included high doses of opioid medication, including fentanyl transdermal. Patient B was diagnosed with lower back pain, lumbar post-laminectomy syndrome, and chronic pain syndrome. As early as 2009, Respondent acknowledged the likelihood of the patient's drug dependence on pain medication and her resistance to reduce her high levels of opioids. In fact, Respondent included in numerous progress notes starting as early as 2011, and continuing through 2014, that the patient's diagnosis of chronic pain was "probably factitious pain disorder."

27. On or about July 26, 2012, Patient B's medication regimen included fentanyl patch 100 mcg, twice every 48 hours, Dilaudid 8 mg, three times per day, Oxycodone 30 mg, six times per day, and other medications. Respondent noted the need to taper opioid therapy, but the patient had "zero interest in reducing medications." It was also noted that the "outlook is poor," but Respondent did not take additional steps to mitigate the risk, including a directed effort to taper opioids when it became apparent that opioid therapy was not effective and the patient had developed an opioid dependency. Respondent indicated he would continue "strong counseling" with the patient, but the patient may have to "move on." Absent from many of the progress notes between 2012 and 2014 were a risk benefit analysis and rationale for high dose opioid therapy, steps used to ensure medication compliance, as well as a defined treatment plan with specific objectives.

28. On or about January 16, 2014, Patient B was still on a high dose opioid therapy, including fentanyl transdermal patch 100 mcg, twice every 48 hours, Dilaudid 8 mg, two times per day, Oxycodone 30 mg, six times per day, and other medications. Respondent noted that even with the patient's current medication regimen, she can only walk for five minutes with a cane. It was noted that the patient continued her resistance to lower the opioid dose. Respondent indicated that he had reduced Patient B's medications from "stratospheric" to "simply extraordinary levels," despite the progress notes reflecting little to no progress regarding tapering. On or about April 10, 2014, Respondent discussed tapering with the patient, but there was no

defined plan and it appeared to include self-tapering with minimal guidance. Patient B was prescribed four different prescriptions for the fentanyl patch with various dosages, which carried a substantial risk. By approximately June 11, 2014, Patient B remained at risk given she continued on high dose opioid therapy and each follow-up visit was at two month intervals.

29. On or about August 9, 2014, Patient B was continued on a dose of opioid therapy greater than 1000 mg or oral morphine equivalent. This high dose represented a substantial risk to the patient of unintended overdose death. Additionally, an untreated or undertreated concomitant psychiatric comorbid disease was not addressed by Respondent, where a mental health referral would have been appropriate under the circumstances. In approximately December 2014, Respondent discharged Patient B from his practice. It was noted that the patient was physically capable of much more activity than expressed, and that "her opioid use is, to a high medical probability, related to physical dependence and psychosocial factors rather than pain." Respondent did not provide the patient with a clear plan of transition for future care or tapering of medication. Patient B was medicated with over 800 mg of oral morphine equivalent at that time. An appropriate discussion regarding alternative therapy and transitioning the patient to a detox facility under the care of an addictionist was lacking. Respondent prescribed the patient with two months of medications and recommended that she seek another pain specialist, rather than appropriately referring her to an addictionist during the transition.

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

(a) Respondent continued the patient on high dose opioid therapy despite a diagnosis of "probably factitious pain disorder;"

(b) Respondent created a substantial risk of harm and unintentional overdose by exposing the patient to prolonged and ineffective high dose opioid therapy;

(c) Respondent failed to document a defined risk benefit analysis regarding opioid therapy;

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(d) Respondent failed to document an appropriate description regarding the rationale for high dose opioid therapy;

(e) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(f) Respondent did not take appropriate steps to ensure medication compliance, such as random urine screens, blood samples, or review of CURES;

(g) Respondent did not provide the patient with an appropriate transition in the setting of iatrogenic escalation;

(h) Respondent failed to refer the patient to an addictionist;

(i) Respondent failed to refer the patient to a mental health professional; and

(j) Respondent did not implement a well-defined and effective plan to taper opioid therapy for harm reduction.

PATIENT C

31. In approximately 1994, Respondent began treating Patient C, a then 52-year-old male, who had a history of lumbar fusion with subsequent reoperation. In approximately 1994, Respondent implanted an intrathecal device in the patient for pain control. Since approximately 2001, Patient C's medication regimen included Actiq fentanyl, Soma, Dilaudid, Percocet, and other medications. By approximately April 30, 2012, the patient's intrathecal medication regimen included fentanyl 4,097 mcg per day, morphine 8.193 mg per day, and other muscle relaxers and numbing agents; Patient C's oral medications included Percocet 325 mg, twice per day, Soma, 350 mg, twice per day, Restoril 30 mg, once per day, Valium 5 mg, twice per day, and Ativan 1 mg, twice per day. This oral medication regimen continued through 2017. Beginning in approximately March 2015, Respondent added Actiq to the patient's oral medication regimen on a regular basis. On or about August 23, 2016, Respondent increased the dosage of intrathecal fentanyl to over 6000 mcg per day, and morphine to 10 mcg per day. The rationale, risk benefit

analysis, and informed consent for high and increasing opioid therapy were not provided. The escalated doses of opioids were substantial and placed the patient at risk of unintended overdose.

32. Progress notes dated August 21, 2014, March 11, 2015, May 31, 2016, and July 11, 2016 were severely limited and missing a risk benefit analysis regarding opioid therapy, a defined treatment plan, a rationale for increasing medication dosages, a rationale for combining medications that increase the risk of respiratory depression, informed consent, medication compliance monitoring, or an adequate physical examination.

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

(a) Respondent failed to document a defined risk benefit analysis regarding opioid therapy;

(b) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(c) Respondent failed to document the rationale for an increased high dose opioid therapy, both intrathecal and orally;

(d) Respondent did not document the rationale for the concomitant administration of oral and intrathecal medications that compounded the effect in the respiratory system;

(e) Respondent prescribed high doses of oral and intrathecal medications concurrently that compounded the patient's risk of harm;

(f) Respondent failed to document informed consent;

(g) Respondent did not conduct an appropriate physical examination; and

(h) Respondent did not take appropriate steps to ensure medication compliance, such as random urine screens, blood samples, or review of CURES.

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PATIENT D

34. In approximately 2008, Respondent began treating Patient D, a then 56-year-old female, who had a history of intractable back pain, addiction, depression and suicidal ideation. She was diagnosed with a lower back degenerative disease, low back pain, spinal stenosis, pain disorder with psychophysiological symptoms, as well as personality disorder. The patient had previously participated in the 12-step program and had untreated psychiatric disorders, both of which add substantial risk for aberrancy to opioid therapy. Patient D had an intrathecal device implanted in approximately 2005.

35. Numerous progress notes[5] from January 2014 through August 2017 are lacking in substantial detail, including a risk benefit analysis regarding opioid therapy, a defined treatment plan, a rationale for increasing medication dosages, a rationale for combining oral and intrathecal medications that increase the risk of respiratory depression, informed consent, medication compliance monitoring, or an adequate physical examination.

36. By approximately August 2016, Respondent regularly prescribed Xanax .25 mg, three to four times per day, oxycodone, 30 mg, nine to ten times per day, Soma 350 mg, three times per day, gabapentin 3600 mg per day, and Actiq. Patient D was also regularly prescribed Restoril 15 mg, one time per day, by another physician at this time. Additionally, Respondent prescribed intrathecal fentanyl to the patient, with increasing doses at almost every appointment between April 2016 and July 2016. In fact, on or about April 4, 2016, Patient D was prescribed 174 mcg of fentanyl per day intrathecally, but by June 22, 2017, the patient was medicated or had access to 13,613 mcg per day of intrathecal fentanyl.

37. On or about July 26, 2017, Respondent noted that Patient D described a constant, stabbing pain, with a pain score of 9/10. This high pain level was despite numerous fentanyl dose escalations. There was no description of objective criteria to gauge the effectiveness of

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[5] These progress notes are dated on or about January 15, 2014, January 23, 2014, February 26, 2014, April 30, 2014, June 18, 2014, July 29, 2014, September 24, 2014, February 18, 2015, March 10, 2015, April 5, 2016, April 7, 2016, and June 15, 2016. Progress notes dated on or about April 19, 2016, May 2, 2016, May 12, 2016, June 6, 2016, July 5, 2016, July 14, 2016, January 26, 2017, April 4, 2017, June 22, 2017, July 26, 2017, and August 10, 2017, also contain the same deficiencies, except that dose escalation of fentanyl via intrathecal pump is noted.

intrathecal therapy. It would have been appropriate to assess whether the targeted drug delivery had failed, or at the very least, whether the risks of continued intrathecal therapy outweighed the benefits. Patient D was continued on high doses of intrathecal fentanyl therapy despite having no documented functional gains. Given that the fentanyl dose was in excess of 13,000 mcg per day with no functional improvement, the dose was clearly excessive and presented an undue risk of harm to the patient.

38. On or about August 10, 2017, sufentanil (which is 5-10 times more powerful than fentanyl), and Dilaudid (which is approximately five times more potent than morphine) are added to Patient D's intrathecal therapy for an alarming total of three separate opioids intrathecally. Patient D was being intrathecally medicated with fentanyl 13,365 mcg per day, sufentanil, 2,673 mcg per day, and Dilaudid, 13.365 mg per day. The total dose of opioids for Patient D at this time was over 35 grams per day of oral morphine equivalent. Ketamine was also added to the patient's intrathecal therapy. There was no rationale documented for adding Ketamine, known to be neurotoxic, to a chronic non-cancer related patient. This intrathecal medication dosage was in addition to the oral medications prescribed by Respondent, including oxycodone 210 mg per day (which equates to approximately 315 mg of oral morphine per day), and respiratory depressant medications such as Xanax and Soma. This oral and intrathecal medication regimen posed a significant risk of harm, neurologic injury, and death to the patient.

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

(a) Respondent failed to document a defined risk benefit analysis regarding opioid therapy;

(b) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(c) Respondent failed to document the rationale for the increased high dose opioid therapy, both intrathecal and orally;

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(d) Respondent did not document the rationale for the concomitant administration of oral and intrathecal medications that compound the effect in the respiratory system;

(e) Respondent failed to document informed consent;

(f) Respondent did not conduct an appropriate physical examination;

(g) Respondent did not take appropriate steps to ensure medication compliance, such as random urine screens, blood samples, or review of CURES;

(h) Respondent prescribed high doses of oral and intrathecal medications concurrently that compounded the patient's risk of harm; and

(i) Respondent did not document the rationale or informed consent when adding Ketamine.

PATIENT E

40. On or about July 12, 2012, Respondent began treating Patient E, a then 54-year-old female, who had a history of neck and back pain, chronic pain, and lumbar disk replacement. Patient E had a personal history of opioid dependence and depression, and an extensive family history of substance abuse. She was diagnosed with neck pain, low back pain, and lower back degenerative disease. By approximately June 2014, Respondent regularly prescribed the patient Soma 350 mg, four times per day, Valium 5 mg, once per day, Norco 325/10 mg, four times per day, MS Contin 60 mg, 3 times per day, as well as other medications. Respondent added Percocet 10/325 mg, eight times per day, in approximately August 2015. Patient E was also prescribed multiple anti-depressants by another physician at this time.

41. On or about March 1, 2016, Respondent's prescribed medication regimen for Patient E included Soma 350 mg, seven times per day, Valium 5 mg, three per day, Norco 325/10 mg, three times per day, MS Contin 30 mg, 3 times per day. The total morphine equivalent was approximately 135 mg per day.

42. Monthly and bi-weekly progress notes from August 2012 through August 2017 are all lacking in substantial detail, including a risk benefit analysis regarding opioid therapy, a

defined treatment plan, a rationale for increasing medication dosages, a rationale for combining concomitant medications, such as Valium and Soma, with opioid medications that increase the risk of respiratory depression, informed consent, medication compliance monitoring, or an adequate physical examination.

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

(a) Respondent failed to document a defined risk benefit analysis regarding opioid therapy;

(b) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(c) Respondent failed to document the rationale for the increased dosing of medications;

(d) Respondent did not document the rationale for the use of concomitant medications, such as Valium and Soma, that compounded the risk of respiratory depression for a patient medicated with chronic opioid therapy;

(e) Respondent failed to document informed consent;

(f) Respondent did not conduct an appropriate physical examination; and

(g) Respondent did not take appropriate steps to ensure medication compliance, such as random urine screens, blood samples, or review of CURES.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, D, and E, as more particularly alleged herein.

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PATIENT A

45. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Paragraphs 22 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT B

46. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Paragraphs 26 through 30, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT C

47. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Paragraphs 31 through 33, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT D

48. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Paragraphs 34 through 39, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT E

49. Respondent committed repeated negligent acts in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Paragraphs 40 through 43, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

50. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to patients A, B, C, D, and E, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 22 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

51. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of patients A, B, C, D, and E, as more particularly alleged in paragraphs 22 through 43, above, which are hereby incorporated by reference and realleged as if 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 No. A 24984, issued to William C. Hopkins, M.D.;

2. Revoking, suspending or denying approval of William C. Hopkins, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering William C. Hopkins, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 9, 2019

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

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