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

In the Matter of the Accusation Against: Bernard Josef Lichtenstein, M.D. Physician's and Surgeon's Certificate No. A 37396 Respondent.	Case No.: 800-2017-038458

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 27, 2021.

IT IS SO ORDERED: July 29, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Vice 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: **BERNARD JOSEF LICHTENSTEIN, M.D.** **3802 National Avenue** **San Diego, CA 92113** **Physician's and Surgeon's Certificate No. A 37396,** Respondent.	Case No. 800-2017-038458 OAH No. 2020120492 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by LeAnna E. Shields, Deputy Attorney General.

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2. Respondent Bernard Josef Lichtenstein, M.D. (Respondent) is represented in this proceeding by attorney Steve Zeigen, Esq., with Rosenberg, Shpall & Zeigen, APC, whose address is: 10815 Rancho Bernardo Road, Suite 310, San Diego, CA 92127.

3. On or about August 31, 1981, the Board issued Physician's and Surgeon's Certificate No. A 37396 to 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. 800-2017-038458, and will expire on September 30, 2021, unless renewed.

JURISDICTION

4. On or about November 5, 2020, Accusation No. 800-2017-038458 was filed before the Board, and is currently pending against Respondent. On or about November 5, 2020, a true and correct copy of Accusation No. 800-2017-038458 and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2017-038458 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2017-038458. Respondent has also carefully read, fully discussed with his counsel, and fully 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. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to each and every charge and allegation contained in Accusation No. 800-2017-038458 and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 37396 to disciplinary action.

9. 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. 800-2017-038458 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.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A 37396 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

11. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify

the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 37396 issued to Respondent BERNARD JOSEF LICHTENSTEIN, M.D., is hereby 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 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. 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.

3. 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, 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. 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.

4. 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.

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

5. 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.

6. 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.

7. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's place of residence, with the exception of telemedicine.

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.

8. 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.

9. 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; Quarterly Declarations.

10. 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.

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11. 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.

12. 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 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.

13. 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.

14. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-038458 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Steven Zeigen, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 37396. 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: 06/23/2021

BERNARD JOSEF LICHTENSTEIN, M.D.
Respondent

I have read and fully discussed with Respondent Bernard Josef Lichtenstein, 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: 6/23/21

STEVEN ZEIGEN, 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: 6/23/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-038458

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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: **BERNARD JOSEF LICHTENSTEIN, M.D.** 3802 National Avenue San Diego, CA 92113 **Physician's and Surgeon's Certificate No. A 37396,** Respondent.	Case No. 800-2017-038458 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about August 31, 1981, the Medical Board issued Physician's and Surgeon's Certificate No. A 37396 to Bernard Josef Lichtenstein, 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 September 30, 2021, unless renewed.

JURISDICTION

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

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

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(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

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. A 37396 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 and B,[1] as more particularly alleged hereinafter.

Patient A

8. On or about March 14, 2016, Patient A, a then 59-year-old male, presented for pain management for chronic pain in his back and knees. Respondent performed a physical examination of Patient A and assessed him with, among other things, lower back pain and back muscle spasm. Records indicate a plan of care which included obtaining Patient A's prior medical records and renewing Patient A's reported prior prescriptions for oxycodone[2] and

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

[2] Oxycodone 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 treatment of moderate to moderately severe pain. The Drug Enforcement Administration (DEA) has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide, 2015 Edition, at p. 43.)

Soma.[3] A urine drug screen and an X-ray of Patient A's lumbar spine was performed during this visit. Respondent issued a 30-day prescription to Patient A for 120 tablets of oxycodone (30 mg) and 120 tablets of Soma (350 mg).

9. The laboratory results from Patient A's urine sample provided on or about March 14, 2016, revealed the presence of carisoprodol, morphine,[4] hydrocodone,[5] and acetaminophen.[6] Oxycodone was not detected. Records do not indicate any discussion between Respondent and Patient A regarding the inconsistent results.[7]

10. From on or about March 14, 2016, through on or about September 18, 2017, according to the California Controlled Substance Utilization Review and Evaluation System (CURES) database,[8] Respondent issued recurring monthly prescriptions to Patient A for Soma and oxycodone without any change in dosage or frequency.

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[3] Soma is a brand name for carisoprodol, a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308.14, and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used as a muscle relaxant. According to the DEA, Office of Diversion Control, published comment on carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs."

[4] Morphine is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Hydrocodone 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 treatment of moderate to moderately severe pain. The DEA has identified opioids, such as hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide, 2015 Edition, at p. 43.)

[6] Vicodin and Norco are brand names for the drug combination of hydrocodone and acetaminophen.

[7] Urine test results are considered "inconsistent" when either prescribed medications are not detected (negative) or non-prescribed medications are detected (positive).

[8] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist healthcare practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Safety Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Safety Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a healthcare practitioner who is treating that patient. (Health & Safety Code, § 11165.1, subd. (a).)

11. From on or about March 14, 2016, through on or about September 18, 2017, Patient A was seen by Respondent at monthly office visits for continued treatment for chronic pain and medication refills.

12. On or about April 18, 2016, Patient A presented for his monthly visit with Respondent. Records for this visit indicate Respondent reviewed Patient A's prior treatment records which revealed past overdoses or altered state of consciousness. Records do not indicate any further assessment of Patient A's past use of controlled substances or any further discussion regarding Patient A's history of overdose. Records indicate Patient A was given precautions about his use of opioids,[9] however, the records do not include a pain management agreement or documentation of a thorough informed consent discussion regarding the risks associated with long-term high dose opioid therapy.

13. On or about June 8, 2016, Patient A presented for his monthly visit with Respondent. Records for this visit indicate Patient A reported an insect bite on his left arm that was red and swollen. Records for subsequent visits indicate this description of Patient A's insect bite was carried forward to several of the remaining visits, until Patient A's last visit with Respondent on or about September 18, 2017. A urine drug screen was performed during this visit.

14. The laboratory results from Patient A's urine sample provided on or about June 8, 2016, revealed the presence of oxycodone, meprobamate,[10] codeine,[11] hydrocodone and acetaminophen. Records do not indicate any discussion between Respondent and Patient A regarding the inconsistent results.

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[9] Opioids (e.g., hydrocodone, fentanyl, and oxycodone) are Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (c), and are dangerous drugs pursuant to Business and Professions Code section 4011. When properly prescribed and indicated, they are generally used for pain management. All opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk prior to prescribing; monitor all patients for misuse, abuse, and addiction."

[10] Meprobamate 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. Meprobamate is also a metabolite of carisoprodol.

[11] Codeine 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.

15. On or about August 10, 2016, Patient A presented for his monthly visit with Respondent. Records for this visit document information copied forward from previous visit notes. A urine drug screen was performed during this visit.

16. The laboratory results from Patient A's urine sample provided on or about August 10, 2016, revealed the presence of oxycodone, hydrocodone and acetaminophen. Carisoprodol and meprobamate were both not detected. Records do not indicate any discussion between Respondent and Patient A regarding the inconsistent results.

17. On or about September 13, 2016, Patient A presented for his monthly visit with Respondent. Records for this visit document a referral to orthopedics. Records for subsequent visits indicate this referral to orthopedics was carried forward to several of the remaining visits, until Patient A's last visit with Respondent on or about September 18, 2017. Records show no documentation of the results of this referral or consultation. A urine drug screen was performed during this visit.

18. The laboratory results from Patient A's urine sample provided on or about September 13, 2016, revealed the presence of carisoprodol, oxycodone, hydrocodone, acetaminophen, morphine, and alcohol. Records do not indicate any discussion between Respondent and Patient A regarding the inconsistent results.

19. On or about October 27, 2016, Patient A presented for his monthly visit with Respondent. Records for this visit indicate Patient A reported increased swelling and pain in his knee. Patient A also reported taking a relative's Percocet to relieve the pain. According to the CURES database, Respondent issued an 8-day prescription to Patient A for 15 tablets of Percocet (10/325).[12] Records for Respondent's care and treatment of Patient A show no documentation of Respondent's prescribing of Percocet to Patient A or any rationale for subsequent increases in the dosages prescribed.

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[12] Percocet (10/325) is a brand name for oxycodone and acetaminophen combination (10 mg oxycodone, 325 mg acetaminophen). Oxycodone 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.

20. From on or about October 27, 2016, through on or about September 18, 2017, according to the CURES database, Respondent issued repeated monthly prescriptions to Patient A for Percocet, with increasing dosages as follows.

Date Filled	Drug Name	Quantity	Days Supply
10/27/16	Percocet (10/325)	15	8
12/14/16	Percocet (10/325)	15	8
1/11/17	Percocet (10/325)	15	7
2/14/17	Percocet (10/325)	15	8
3/16/17	Percocet (10/325)	15	4
4/14/17	Percocet (10/325)	20	5
5/16/17	Percocet (10/325)	20	5
6/20/17	Percocet (10/325)	30	8
7/20/17	Percocet (10/325)	30	8
8/17/17	Percocet (10/325)	30	8
9/18/17	Percocet (10/325)	30	8

21. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any consideration or attempt to treat Patient A's pain with non-opioid treatment modalities, including, but not limited to, physical therapy, epidural injections, nerve block therapies, weight loss exercise, acupuncture, or chiropractic therapy.

22. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any consideration or attempt to treat Patient A's pain with a multi-disciplinary approach including, but not limited to, anesthesia interventions, orthopedic surgery, cognitive behavioral therapy or primary care coordination.

23. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any thorough informed consent discussion of the risks and toxicity of the medications prescribed, risks of drug dependency and drug overdose, and/or any pain care agreement or pain contract.

24. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any risk assessment for addiction or abuse of controlled substances.

25. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any objective and/or subjective measurement and/or evaluation of Patient A's pain levels.

26. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any assessment of Patient A's pain management, including but not limited to, analgesia, adverse side effects, activity level, aberrancy and affect.

27. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any discussion regarding the effectiveness and/or the presence of any adverse side effects of the prescribed medications.

28. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any attempt to taper and/or reduce the medication regimen prescribed by Respondent to Patient A.

29. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any attempt to monitor the Morphine Equivalent Dose (MED)[13] prescribed to Patient A or the rationale for prescribing such high morphine equivalent dosages to Patient A.

30. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any consideration of prescribing naloxone[14] antidote therapy despite Patient A's high dose opioid therapy creating a high risk of overdose and respiratory failure.

31. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any consultation of the CURES database by Respondent.

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[13] Morphine Equivalent Dose (MED), also commonly referred to as Morphine Milligram Equivalent (MME), is used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED or MME. MED/MME calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations. In general, the standard of practice is to limit a patient's opioid dose to less than 50 MED/MME in most patients receiving opioid treatment for chronic pain, and to exceed 90 MED/MME in only the most unusual circumstances.

[14] Naloxone, brand name Narcan, is a dangerous drug pursuant to Business and Professions Code section 4022, commonly prescribed to treat acute opioid overdose.

32. Throughout the course of Respondent's care and treatment of Patient A, records show no indication of any discussion regarding the inconsistent urine drug screen results.

33. Throughout the course of Respondent's care and treatment of Patient A, records contained content that failed to adequately and/or accurately describe observations, discussions, or conduct occurring on the date indicated, but rather was generated by default by the medical record keeping system or was copied forward from prior visit notes.

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

A. Paragraphs 8 through 33, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to properly initiate and/or monitor Patient A's treatment of chronic pain with opioid medications; and

C. Respondent failed to appropriately document and/or maintain appropriate documentation of his care and treatment provided to Patient A.

Patient B

35. In or around 2014, Respondent began treating Patient B, a then 54-year-old male, for, among other things, diabetes, neuropathy, pancreatitis, renal failure, peripheral vascular disease, avascular necrosis of the hips, and chronic pain in the knees, hips and back. Records indicate Patient B also had a medical history of schizophrenia and alcoholism.

36. From on or about May 13, 2014, through on or about May 11, 2016, Patient B presented for monthly visits with Respondent. Records for these visits provide limited descriptions of Patient B's medical history, vitals and physical exams. Records for these visits often failed to document, among other things, any review of systems, medications, social history or plan of care. Records for these visits do not document a pain management agreement or any thorough informed discussion regarding the risks associated with long-term high dose opioid therapy.

37. On or about September 11, 2014, Patient B presented for his monthly visit with Respondent. Records for this visit indicate Patient B reported falling down and hurting his knee

three weeks earlier. Records for this visit also indicate Patient B's history of alcoholism resulting in pancreatic insufficiency and diabetes.

38. On or about November 11, 2014, Patient B presented for his monthly visit with Respondent. Records for this visit indicate Patient B met with an orthopedic surgeon regarding possible hip surgery. Records from this consultation are not documented, but records indicate Patient B was not a candidate for surgery due to his diabetes and young age. An MRI referral was also requested due to Patient B's low scores on a recent cognitive test. Records for this visit also indicate Patient B reported falling down a flight of stairs years earlier. Records indicate a plan to refill Patient B's prescriptions for morphine and oxycodone, but no further details regarding these prescriptions is documented.

39. On or about December 10, 2014, Patient B presented for his monthly visit with Respondent. Records for this visit are completely blank. A urine drug screen was performed during this visit. The laboratory results from Patient B's urine sample revealed the presence of oxycodone, morphine, and alcohol.

40. On or about December 16, 2014, Patient B underwent an MRI of the brain. Imaging reports indicated no acute intracranial abnormality and mild chronic small vessel ischemic disease of white matter.

41. On or about January 9, 2015, records indicate Respondent attempted to contact Patient B by phone for his monthly visit for pain management. Records indicate there was no contact made by phone, however, vital signs are recorded for this date.

42. On or about February 6, 2015, Patient B presented for his monthly visit with Respondent. Other than vital signs, records for this visit are completely blank.

43. On or about March 6, 2015, Patient B presented for his monthly visit with Respondent. Other than vital signs, records for this visit are completely blank.

44. On or about March 18, 2015, Patient B presented for a Doppler analysis of his carotid. Records for this evaluation are completely blank.

45. On or about April 1, 2015, Patient B presented for his monthly visit with Respondent. Records for this visit are completely blank.

46. On or about April 7, 2015, Patient B presented for medication refills with another physician at the same clinic as Respondent. Records for this visit indicate Patient B reported falling and fracturing his right fibula.

47. On or about May 4, 2015, Patient B presented for his monthly visit with Respondent. Records indicate Patient B requested a refill of his medications and an MRI of his legs. Other than vital signs, records for this visit are completely blank. According to the CURES database, Respondent issued a prescription to Patient B for 60 tablets of morphine (60 mg) and 235 tablets of oxycodone (30 mg). Records for this visit do not document this change in prescription for oxycodone or the rationale for the lowered quantity of oxycodone.

48. On or about June 9, 2015, Patient B provided a urine sample. The laboratory results from Patient B's urine sample revealed the presence of morphine, but the absence of oxycodone. Records do not indicate any discussion between Respondent and Patient B regarding the inconsistent results.

49. On or about July 1, 2015, Patient B presented for his monthly visit with Respondent. Records for this visit documents information copied forward from previous visit notes. According to the CURES database, Respondent issued a prescription to Patient B for 60 tablets of morphine (60 mg) and 180 tablets of oxycodone (30 mg). Records for this visit do not document this change in prescription for oxycodone or the rationale for the lowered quantity of oxycodone.

50. On or about November 25, 2015, Patient B had a telephone visit with Respondent. Records for this encounter indicate Patient B reported drinking "a lot of beer" while watching sports events.

51. On or about February 17, 2016, Patient B presented for his monthly visit with Respondent. Records for this visit documents information copied forward from previous visit notes. A urine drug screen was performed during this visit. The laboratory results from Patient B's urine sample revealed the presence of oxycodone and alcohol, but the absence of morphine. Records do not indicate any discussion between Respondent and Patient B regarding the inconsistent results.

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52. On or about March 9, 2016, Patient B presented for his monthly visit with Respondent. Records for this visit documents information copied forward from previous visit notes. A urine drug screen was performed during this visit. The laboratory results from Patient B's urine sample revealed the absence of morphine and oxycodone. Records do not indicate any discussion between Respondent and Patient B regarding the inconsistent results.

53. From on or about January 21, 2014, through on or about May 9, 2016, according to the CURES database, Respondent issued recurring monthly prescriptions to Patient B for 60 tablets of morphine (60 mg) without any change in dosage of frequency. Respondent's records for these visits do not document these prescriptions or indicate any rationale for prescribing such a high dosage to Patient B.[15]

54. From on or about January 21, 2014, through on or about March 14, 2015, according to the CURES database, Respondent issued repeated monthly prescriptions to Patient B for 240 tablets of oxycodone (30 mg). Respondent's records for these visits do not document these prescriptions or indicate any rationale for prescribing such a high dosage to Patient B.[16]

55. On or about May 11, 2015 and June 11, 2015, according to the CURES database, Respondent issued two monthly prescriptions to Patient B for 235 tablets of oxycodone (30 mg). Respondent's records for these visits do not document these prescriptions, indicate any rationale for prescribing such a high dosage to Patient B, or the reason for the slight decrease in quantity prescribed during these two months.

56. From on or about July 10, 2015, through on or about May 9, 2016, according to the CURES database, Respondent issued repeated monthly prescriptions to Patient B for 180 tablets of oxycodone (30 mg). Respondent's records for these visits do not document these prescriptions, indicate any rationale for prescribing such a high dosage to Patient B,[17] the reason

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[15] A monthly prescription for 60 tablets of morphine (60 mg) has an MED of 120.

[16] A monthly prescription for 240 tablets of oxycodone (30 mg) has an MED of 360. When combined with the morphine prescription, Respondent was prescribing a total of 480 MED to Patient B.

[17] A monthly prescription for 180 tablets of oxycodone (30 mg) has an MED of 270. When combined with the morphine prescription, Respondent was prescribing a total of 390 MED to Patient B.

for the decrease in quantity prescribed during these months, Patient B's response to the lower dosage, or any attempt or plan to further taper Patient B's prescription regimen.

57. Throughout the course of Respondent's care and treatment of Patient B, records show minimal consideration or attempt to treat Patient B's pain with non-opioid treatment modalities, including, but not limited to, physical therapy, epidural injections, nerve block therapies, weight loss exercise, acupuncture, or chiropractic therapy.

58. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any thorough informed consent discussion of the risks and toxicity of the medications prescribed, risks of drug dependency and drug overdose, and/or any pain care agreement or pain contract.

59. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any risk assessment for addiction or abuse of controlled substances.

60. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any objective and/or subjective measurement and/or evaluation of Patient B's pain levels.

61. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any assessment of Patient B's pain management, including but not limited to, analgesia, adverse side effects, activity level, aberrancy and affect.

62. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any discussion regarding the effectiveness and/or the presence of any adverse side effects of the prescribed medications.

63. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any attempt to taper and/or reduce the morphine medication prescribed by Respondent to Patient B.

64. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any attempt to monitor the MED prescribed to Patient B or the rationale for prescribing such high morphine equivalent dosages to Patient B.

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65. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any consideration of prescribing naloxone antidote therapy despite Patient B's high dose opioid therapy creating a high risk of overdose and respiratory failure.

66. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any consultation of the CURES database by Respondent.

67. Throughout the course of Respondent's care and treatment of Patient B, records show no indication of any discussion regarding the inconsistent urine drug screen results.

68. Throughout the course of Respondent's care and treatment of Patient B, records contained content that failed to adequately and/or accurately describe observations, discussions, or conduct occurring on the date indicated, but rather was generated by default by the medical record keeping system or was copied forward from prior visit notes.

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

A. Paragraphs 35 through 68, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to properly initiate and/or monitor Patient B's treatment of chronic pain with opioid medications; and

C. Respondent failed to appropriately document and/or maintain appropriate documentation of his care and treatment provided to Patient B.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

70. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 37396 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A and B, as more particularly alleged hereinafter.

Patient A

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

A. Paragraphs 8 through 34, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to consider and/or appropriately utilize non-opioid treatment modalities for the treatment of Patient A's chronic pain; and

C. Respondent failed to have a thorough informed consent discussion with Patient A regarding the toxicity of the controlled substances prescribed and failed to obtain a pain care agreement from Patient A.

Patient B

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

A. Paragraphs 35 through 69, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to consider and/or appropriately utilize non-opioid treatment modalities for the treatment of Patient B's chronic pain; and

C. Respondent failed to have a thorough informed consent discussion with Patient B regarding the toxicity of the controlled substances prescribed and failed to obtain a pain care agreement from Patient B.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

73. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 37396 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and/or accurate medical records regarding his care and treatment of Patients A and B, as more particularly alleged in paragraphs 7 through 72, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Provisions of the Medical Practice Act)

74. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 37396 to disciplinary action under sections 2227 and 2234, as defined by section 2234,

subdivision (a), of the Code, in that he violated provisions of the Medical Practice Act in his care and treatment of Patients A and B, as more particularly alleged in paragraphs 7 through 73, 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 37396, issued to Respondent Bernard Josef Lichtenstein, M.D.;

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

3. Ordering Respondent Bernard Josef Lichtenstein, 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: NOV 05 2020

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

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