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

In the Matter of the Accusation Against: Carlos A. Alvarez, M.D. Physician's and Surgeon's Certificate No. A 42986 Respondent.	Case No.: 800-2018-041316 and 800-2019-055378

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 May 12, 2023.

IT IS SO ORDERED: April 14, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2320
Facsimile: (559) 445-5106
Attorneys for Complainant

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

In the Matter of the Accusations Against: **CARLOS A. ALVAREZ, M.D.** **6001B Truxtun Ave.,#220** **Bakersfield, CA 93309-0611** **Physician's and Surgeon's Certificate No. A 42986** Respondent.	Case No. 800-2018-041316 OAH No. 2021040208 & Case No. 800-2019-055378 OAH No. Unassigned **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. William Prasifka was the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity. Reji Varghese (Complainant) is the Interim Executive Director of the Board and brings this action solely in his official capacity,

and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Lynette D. Hecker, Deputy Attorney General.

2. Carlos A. Alvarez, M.D. (Respondent) is represented in this proceeding by attorney Dennis R. Thelen, Esq., whose address is: 5001 E. Commerce Center Dr., Ste 300, Bakersfield, CA 93309-1687.

3. On or about August 15, 1986, the Board issued Physician's and Surgeon's Certificate No. A 42986 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. 800-2018-041316 and Accusation No. 800-2019-055378, and will expire on November 30, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-041316 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 February 22, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-041316 is attached as "Exhibit A" and incorporated herein by reference.

6. Accusation No. 800-2019-055378 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 April 29, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

7. A copy of Accusation No. 800-2019-055378 is attached as "Exhibit B" and incorporated herein by reference.

ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands both the charges and allegations in both Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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9. 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.

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

CULPABILITY

11. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

12. Respondent agrees that, at an administrative hearing, Complainant could establish a *prima facie* case or factual basis with respect to the charges and allegations in both Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378, that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 42986 to disciplinary action, and Respondent hereby gives up his right to contest those charges.

13. 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.

RESERVATION

14. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

15. 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.

16. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in both Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378 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.

17. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 42986, issued to Respondent CARLOS A. ALVAREZ, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. 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 may delay assessment under that program until the earliest available date on or after June 1, 2023. Respondent shall successfully complete the program not later than six (6) months after Respondent begins the

assessment 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. The 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 the Respondent did not successfully complete the clinical competence assessment program, the 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.

Within 60 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include 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, or until the Board or its designee determines that further participation is no longer necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The monitor 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 ten (10) calendar days after the end of the preceding quarter.

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

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart

review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

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

8. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

9. 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.

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $13,800 (thirteen thousand eight hundred dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to

repay investigation and enforcement costs, including expert review costs (if applicable).

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

dates of departure and return.

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

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

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the

exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

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

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

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

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

19. 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 both Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378 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, Dennis R. Thelen, 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: _____ _____

CARLOS A. ALVAREZ, M.D.
Respondent

I have read and fully discussed with Respondent Carlos A. Alvarez, 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: _____ _____

DENNIS R. THELEN, ESQ.
Attorney for Respondent

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19. 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 both Accusation No. 800-2018-041316 and Accusation No. 800-2019-055378 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, Dennis R. Thelen, 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: 4/5/23

CARLOS A. ALVAREZ, M.D.
Respondent

I have read and fully discussed with Respondent Carlos A. Alvarez, 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: 4-7-23

DENNIS R. THELEN, ESQ.
Attorney for Respondent

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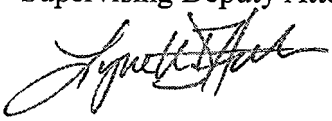
ENDORSEMENT

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

DATED: 4/12/2023

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General



LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-041316

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2320
Facsimile: (559) 445-5106
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Carlos A. Alvarez, M.D.** **5400 Aldrin Ct.** **Bakersfield, CA 93313-2103** **Physician's and Surgeon's Certificate No. A 42986,** Respondent.	Case No. 800-2018-041316 **ACCUSATION**

PARTIES

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

2. On or about August 15, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number A 42986 to Carlos A. Alvarez, 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 November 30, 2021, unless renewed.

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JURISDICTION

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

STATUTORY PROVISIONS

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:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated

negligent acts.

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

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.

FACTUAL ALLEGATIONS

PATIENT 1[1]

8. Patient 1 is a female who was approximately 68 years old when she first began seeing Respondent, on or about August 8, 2015. Patient 1 was seen by Respondent and/or his staff approximately 118 times in approximately forty-five months, from on or about August 8, 2015, through on or about February 28, 2019. At the last of these visits, Patient 1 was approximately 71 years old. Patient 1's medical conditions during the times at issue herein included, but were not limited to: glaucoma; thyroid solitary nontoxic nodule; hypertension; hyperlipidemia;

[1] The patients' names are redacted to protect their privacy.

gastroesophageal reflux disease (GERD); diabetes; vitamin D deficiency; osteopenia;[2] and a history of hysterectomy (at age 28) as well as a total right hip arthroplasty.

Unlicensed Practice of Medicine

9. Respondent allowed staff who were not licensed physicians or mid-level providers to practice medicine. Specifically, on at least three occasions, on or about February 2, 2018, on or about February 26, 2018, (or on or about February 28, 2018), and on or about March 16, 2018, Respondent allowed an unlicensed, foreign medical school graduate (FMSG) to examine, diagnose, form treatment plans, make referrals, order/perform treatments (including but not limited to injections, removal of skin tags, cryotherapy), as well as direct use of medication and discuss side effects and risks thereof with Patient 1 in his stead. Patient 1 did not see Respondent and was only seen by the FMSG on at least those three dates in 2018. Respondent condoned non-provider staff practicing medicine and, prior to at least one appointment, on or about April 6, 2018, Respondent preauthorized the FMSG to see Patient 1 if he was unavailable.

10. The standard of care is to restrict the practice of medicine to providers trained and licensed as physicians or mid-levels like nurse practitioners (NP) or physician assistants (PA).

11. Respondent's acts of allowing the FMSG, who was neither a licensed physician nor a mid-level provider, to practice medicine by seeing and examining Patient 1 in his stead, on or about February 2, 2018, on or about February 26, 2018, and on or about March 16, 2018, constitutes gross negligence and unprofessional conduct.

Access to Physician Electronic Medical Records (EMR) Account Credentials

12. During the time that Patient 1 was under Respondent's care, Respondent's staff had access to his log-on credentials and could enter data in his name in patient charts. This presents a risk of allowing or condoning unlicensed practice of medicine, and allows other individuals to masquerade as Respondent. On or about February 2, 2018, on or about February 26, 2018, and on or about March 16, 2018, the FMSG saw Patient 1, and recorded authorship within the EMR note header that Respondent was the medical provider on those dates.

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[2] Osteopenia, also known as "low bone mass" or "low bone density," is a condition in which bone mineral density is low. Because their bones are weaker, people with osteopenia may have a higher risk of fractures, and some people may go on to develop osteoporosis.

13. The standard of care is to protect each provider's log-on credentials and passwords and prohibit their use by other providers and all unlicensed staff, to prevent any fraudulent masquerading as the provider in question.

14. Respondent's failure to prohibit or prevent staff from utilizing his log-on credentials and passwords in the EMR constitutes gross negligence and unprofessional conduct.

Hypertension Management

15. During Patient 1's 118 visits, her hypertension (HTN) was generally uncontrolled. The goal for a diabetic is for their systolic blood pressure (SBP) to be below 140. Patient 1's SBP on her 118 visits ranged between 144-198, except for eleven visits when it measured less than 140. Her lowest SBP of 93 was taken on or about September 17, 2018. Her next lowest SBP of 114 was taken on or about August 4, 2016. Out of Patient 1's 118 visits, there were several visits in which no blood pressure measurement was recorded. On or about February 8, 2017, Patient 1 was prescribed amlodipine[3] 10 mg daily. This was the first medication for high blood pressure prescribed for Patient 1, but was a suboptimal choice for a diabetic at that time. On or about August 1, 2017, Patient 1 was switched to losartan[4] 100 mg daily. On or about November 8, 2017, though her blood pressure was 162/78, Patient 1 was instructed to stop taking amlodipine. On or about November 27, 2018, Respondent's NP switched Patient 1 to a lower potency medication for high blood pressure, lisinopril[5] 10 mg, despite her blood pressure reading of 152/81. Patient 1's SBP was uncontrolled at most visits despite medication. However, there was no documentation of recognition of lack of control or additional interventions to promote control.

16. Home blood pressure machine readings were never solicited from Patient 1. Patient 1's average blood pressure over her last few visits was never calculated and, with the exception of eleven out of 118 visits, a controlled blood pressure was never achieved. Most of the time only a

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[3] Amlodipine is a calcium channel blocker that dilates (widens) blood vessels and improves blood flow. Amlodipine is used to treat chest pain (angina) and other conditions caused by coronary artery disease. Amlodipine is also used to treat high blood pressure (hypertension).

[4] Losartan is used to treat high blood pressure (hypertension) and to help protect the kidneys from damage due to diabetes. It is also used to lower the risk of strokes in patients with high blood pressure and an enlarged heart.

[5] Lisinopril is an ACE inhibitor. ACE stands for angiotensin converting enzyme. Lisinopril is used to treat high blood pressure (hypertension) in adults and children who are at least 6 years old.

single antihypertensive agent at a time was prescribed for Patient 1, and on one occasion, on or about November 27, 2018, Patient 1's prescription was actually reduced from the maximal equivalent dose of antihypertensive despite her SBP persistently being elevated above goal. Respondent's records rarely document an attempt to use two or more anti-hypertensive medications concurrently in his treatment of Patient 1's hypertension.

17. The standard of care in managing hypertension is to identify the pertinent target blood pressure goal below which to strive, track the patient's average blood pressure response to medication intervention, and adjust medications until control is reached, while monitoring for adverse effects of treatment. For a diabetic, the target control is below 140/90. The typical hypertensive patient requires at least two anti-hypertensive medications taken at different times of the day. It is not unusual for a primary care physician to manage up to three concurrent anti-hypertensive medications to achieve control in the majority of patients.

18. Respondent's allowing Patient 1's SBP to remain above goal without making any new intervention for the vast majority of her 118 evaluations including, but not limited to SBP readings greater than, or equal to 150, on or about August 8, 22, 26 and November 20, 2015; on or about April 20 and 27, 2016; on or about December 23, 2017; on or about January 5, February 14, April 6, 23, 30, July 10, 12, 16, 23, August 1, 13, 17, 27, and October 1, 2018; and on or about January 26, 2019, constitutes gross negligence.

Hyperlipidemia Management

19. On or about April 14, 2016, Patient 1's lab results showed her cholesterol, specifically her low density lipoprotein (LDL) was 198, which is extremely elevated. However, these results were not recognized in Respondent's two subsequent notes, nor were they recognized when other lab results of the same day were acknowledged. This result was also not rechecked until approximately eleven visits later, on or about September 27, 2016. During this entire time, Patient 1 had additional treatment indications of diabetes mellitus (DM), with an

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additional cardiovascular risk factor of HTN. However, Respondent failed to order a statin medication, simvastatin,[6] for her until over a year later.[7]

20. The standard of care in managing hyperlipidemia is to initiate statin medication in the absence of contraindications for patients demonstrating severe (greater than or equal to 190 LDL) elevation.

21. Respondent's ordering of a lab test and failure to review and act upon an abnormal result for over 5 months, as well as failing to start an indicated treatment for over a year, constitutes negligence.

Pre-Op Risk Assessment/Clearance

22. On or about August 1, 2017, Respondent performed a pre-operative evaluation of Patient 1 for planned hip replacement, which is a major orthopedic surgery requiring general anesthesia that has a known risk for intra-operative blood loss. Patient 1's electrocardiogram (EKG) showed findings that can be associated with a recent silent heart attack in a diabetic, such as Patient 1, who has multiple coronary artery risk factors of uncontrolled hypertension and hyperlipidemia. Alternatively, the findings may have been a manifestation of an undiagnosed critical coronary artery ischemic lesion. Both of these potential conditions can fatally decompensate in seconds during the stress of surgery, such that Respondent should have referred Patient 1 to a cardiologist for further evaluation for intervention before surgery. Instead, Respondent identified Patient 1's severely decompensated high blood pressure, of 192/94, for which he prescribed a second agent, losartan, without any documented attempt to ascertain if his office practice has authorized refills for Patient 1's first anti-hypertensive medication, amlodipine. This medication had last been filled, with a pill count of 90, on or about May 30, 2017, which was more than 90 days prior to that appointment and had neither been subsequently prescribed or filled since. Respondent took no steps to defer surgery until Patient 1 could be reassessed for

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[6] Simvastatin belongs to a group of drugs called HMG CoA reductase inhibitors, or "statins." Simvastatin is used to lower blood levels of "bad" cholesterol (low-density lipoprotein, or LDL), to increase levels of "good" cholesterol (high-density lipoprotein, or HDL), and to lower triglycerides (a type of fat in the blood).

[7] This medication first appears on Respondent's medication list in Patient 1's chart on or about August 1, 2017, but Patient 1's insurance shows a pharmacy claim for it being first filled on or about June 21, 2017.

resolution of her severely elevated blood pressure. Further, Respondent documented chest X-ray findings of a lung infiltrate and an elevated white blood cell count with a left shift, both of which are potentially manifestations of bacterial pneumonia in a patient, such as Patient 1, with immune compromising underlying diabetes. Proceeding with the surgery in light of these findings risks inpatient decompensation and threatens a pulmonary infection site that could risk spread to sepsis and seed the planned metal hip prosthesis with catastrophic complications, including an infected prosthetic joint.

23. The standard of care for performing a pre-operative evaluation is to examine the patient for possible, serious, unaddressed or uncontrolled problems with the potential for exacerbation by the stress of surgery, including induction of anesthesia, intubation, fluid shifts from blood loss and IV administration, and post-operative pain that can decompensate in seconds to weeks during the 30-day peri-operative period during and after surgery. Once such problems are discovered, the standard of care is to recommend the requesting surgeon defer elective procedures until the patient is treated, stabilized, and their medical problems reasonably well controlled before granting clearance for surgery.

24. Respondent's failure to recognize the significance of the abnormal EKG findings or to refer Patient 1 for cardiology specialist evaluation, his failure to recommend deferral of this elective joint replacement surgery until Patient 1's severely decompensated hypertension is better controlled, his failure to recognize and evaluate for treatment a possible undiagnosed pneumonia, and his granting of clearance for Patient 1 to proceed with elective surgery constitutes gross negligence.

Judicious Use of Antibiotics

25. On or about July 12, 2018, Respondent's NP treated Patient 1 for a skin tear on her forearm. Patient 1's temperature was normal, as was the findings of the NP's exam of her skin. There is no documentation of redness or pus, no diagnosis of bacterial infection, nor documentation of a diagnosis thereof to support the administration of any antibiotic, let alone the additional risks of an injectable antibiotic. Despite this, Patient 1 was given an injection of

ceftriaxone[8] antibiotic without any supporting explanation. Respondent took no steps to discourage the unnecessary administration by intramuscular route of medications for which there are safer and equally acceptable oral alternatives in the absence of severity of illness to necessitate an injection.

26. The standard of care for the use of antibiotics is to limit their use to situations in which the benefit to the patient exceeds the risks of allergic reactions, to avoid fostering multi-drug resistant pathogens and complications of intramuscular injection like pain, scarring, vasovagal syncope, and injection site inflammation or infection.

27. The administration of an intramuscular antibiotic, ceftriaxone, to Patient 1 in the absence of any demonstrated or documented indication by Respondent's NP constitutes negligence. Further, Respondent's failure to discourage the unnecessary intramuscular administration of medications, for which there are safer and equally acceptable oral alternative, in the absence of severity of illness warranting the speed of injection constitutes negligence.

Hormone Replacement Therapy (HRT)

28. Respondent ordered ten long acting injections of estradiol cypionate, a form of HRT, for Patient 1 from on or about October 27, 2015, to on or about August 30, 2018. Included therein were five, 5 mg doses, from on or about April 20, 2016, to on or about May 18, 2016, for a total of 25 mg in less than 30 days -- which is more than five times the dose for postmenopausal patients. The initial dose, on or about October 27, 2015, was suggested by a NP student Respondent was supervising, based on a history of hot flashes and night sweats without any more detailed investigation on the impact on Patient 1's functioning. Further, the severity and frequency of Patient 1's complaints was also not documented to justify or provide reason to initiate HRT intervention in Patient 1, who had a hysterectomy at an early age and was a decade or more older than the typical age of menopause. Further, Respondent failed to document why less risky and less invasive oral supplementation would not suffice.

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[8] Ceftriaxone for injection, is a sterile, semisynthetic, broad-spectrum, third generation cephalosporin antibiotic for intravenous or intramuscular administration.

29. The standard of care is to limit the use of HRT to those significant, severe symptoms impairing quality of life or functioning and to use them for the shortest duration necessary to provide relief. These agents are available in oral formulations tolerated by the vast majority of patients needing treatment. The average duration of troublesome climacteric menopausal symptoms like severe flushing or sweats is on the order of a decade after the onset of menopause typically in the early 50s. It is uncommon for female seniors, 65 years of age and older, to exhibit severity of symptoms necessitating HRT. In the infrequent indicated candidates who have a justifiable preclusion to oral administration, the typical dose of estradiol cypionate is 5 mg every 3-4 weeks.

30. Respondent's initiation of HRT without documented indication of a severity of symptoms warranting late menopause use, absent a documented reason the oral route could not be used, and at a frequency and/or dose five times higher than the recommended maximum constitutes gross negligence.

Monitoring Lab Tests

31. On or about April 16, 2016, Respondent's office received lab reports showing Patient 1 had a severe, life threatening elevation of sodium (Na) at 157, and milder elevation of potassium (K) at 5.9. The elevated potassium, though milder, approaches the level at which dangerous cardiac arrhythmias can occur. These lab reports were not documented as recognized. Further, no treatment was provided to Patient 1 to address either of these abnormal results in subsequent evaluation notes on or about April 20, 2016, or on or about April 27, 2016 -- the latter of which explicitly notes other results from the same lab report and indicates "lab test results reviewed with patient."

32. On or about July 11, 2018, another lab report was received which showed Patient 1 had a now marked elevation of potassium (K) at 6.2. Elevated potassium in that range can contribute to coma, lethal cardiac arrhythmias, and death. At that time, Patient 1 was on losartan, for her high blood pressure, which is known to cause potassium elevation. However, Patient 1's elevated potassium and taking losartan was not recognized, reported, or addressed at her next 19 visit dates, from on or about July 16, 2018, through on or about September 13, 2018. Patient 1's

potassium levels were not monitored or tested again until she had an ER visit with outside providers on or about September 14, 2018.

33. The standard of care is to review all lab test reports received, determine which merit attention, and further select those of higher risk of progressing to death or disability for expedited interventions.

34. The absence of a same to next day response by Respondent and/or his office to severe or critically abnormal lab results, such as those reflecting Patient 1's elevated sodium and potassium levels on or about April 16, 2016, and on or about July 11, 2018, constitutes gross negligence.

Calcium Supplementation

35. On or about February 7, 2018, Patient 1 had a borderline bone density report of osteopenia. On or about February 14, 2018, Respondent prescribed calcium 600 mg twice daily for Patient 1 despite having prior normal and elevated laboratory calcium measurements for her. Her then most recent prior lab test, on or about August 18, 2017, showed an absence of low calcium, and an earlier test, on or about April 14, 2016, showed Patient 1 had an elevated calcium of 10.9. Patients such as Patient 1 with osteopenia, whose calcium level is normal, are not at a lower risk of progressing to osteoporosis when unnecessary calcium is administered, but in fact are at a higher risk of kidney stone formation with such supplementation.

36. The standard of care is to supplement calcium only for patients with a confirmed deficit on laboratory testing. Although such supplementation was common in previous decades, subsequent studies showed no benefit on preventing bone loss and an increase in the adverse consequence of kidney stone formation in patients with normal calcium stores.

37. Respondent's ordering of calcium supplementation, on or about February 14, 2018, for Patient 1 who had borderline osteopenia and normal to elevated calcium levels, constitutes negligence.

Exposure to CT Scan Ionizing Radiation

38. On or about September 14, 2018, the NP under Respondent's supervision evaluated Patient 1 for follow-up from an ER visit the patient had earlier that morning for pelvic pain. The

NP reviewed all lab reports from the hospital and a CT of the head performed in the hospital that had negative results. Patient 1 also had a CT of her abdomen and pelvis with intravenous contrast in the hospital. However, the NP failed to recognize that Patient 1 had an abdominal CT earlier that same day in the ER. The NP was at least partially aware that Patient 1 had been evaluated in the ER, as she acknowledged the ER CT test results of that same date for another body region. Nonetheless, the NP ordered an almost identical abdominal CT to that which Patient 1 had in the ER. Such a duplicate CT would not have been expected to yield much, if any, additional information to justify the risk of exposing Patient 1 to a third CT radiation dose that day.

39. The standard of care is to order only indicated tests for the patient's concerns for which the information returned is anticipated to be of greater benefit than the risks incurred by the testing. This is particularly relevant in exposure to CT scan radiation, which can be higher than simple plain films and cumulatively increase a patient's risk of cancer.

40. The ordering of a second abdominal CT scan by the NP, who was under Respondent's supervision, the same day that Patient 1 had already had an abdominal CT scan performed in the ER constitutes negligence.

Bladder Outlet Obstruction

41. On or about December 13, 2018, the NP under Respondent's supervision, examined Patient 1 and found that she had a palpable bladder, but no changes in urine. The NP prescribed tolteradine, a medication to relax the prostatic urethra in men, which is inappropriate for women since they lack prostates. Tolteradine is infrequently prescribed for women when other treatments are ineffective for overactive bladder (which is associated with bladders that do not fill completely and would not be expected to be palpable). The NP failed to address sufficient additional detail to support the diagnosis of retention of urine, failed to consider or conduct a pelvic exam, and failed to seek ultrasound confirmation or possible causes of urinary retention. Since Patient 1 was post hysterectomy, outlet obstruction was unlikely, and the tolteradine prescribed by the NP would not have a role in Patient 1's treatment since there were no documented symptoms of an overactive bladder.

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42. The standard of care for diagnosing and treating bladder outlet obstruction is to fully evaluate the cause before initiating treatment. More common causes of such obstructions in men include prostatic hypertrophy, and in women prolapse of the uterus. Less common causes in both genders include bladder stones or cancers. A pelvic exam in women and a digital rectal exam of the prostate in men is sometimes useful, as is ultrasound imaging of the bladder. Tolteradine is an alpha adrenergic blocker with increased affinity for the bladder sphincter, sometimes useful in men with prostatic hypertrophy, and less frequently in women for opposite overactive bladder that is not associated with obstruction.

43. Prescribing tolteradine based merely on a finding of suspected palpable bladder, without considering or conducting a pelvic exam or bladder ultrasound in Patient 1, who is a post hysterectomy female in whom outlet obstruction would be less common, constitutes negligence.

Recordkeeping

44. Respondent failed to sign off many of Patient 1's exam notes, and signed others many months after the fact. Many of Respondent's evaluations of Patient 1 reflect "not signed" in the header field. Other notes in Patient 1's chart (from on or about the following dates: August 8, 22, 26, 29 of 2015; September 9, 2015; October 27, 2015; and April 13, 20, 27 of 2016) were signed more than six months after the events reflected therein occurred.

45. The standard of care is to maintain the integrity of medical records and mitigate the risk of destruction or falsification by fraudulent alteration or modification after the fact. With EMR, this requires the vendor to write software preventing providers from fraudulently altering records after the fact by preventing editing or changing the record once the visit is signed off. Ideally, providers should complete notes by the day's end, or infrequently by the end of the subsequent scheduled office hours, and sign off irrevocably saving each note after which the software prevents further changes.

46. Respondent's failure to either sign his notes, or to timely sign off and permanently save an unalterable record of care, on or about the following dates: August 8, 22, 26, 29 of 2015; September 9, 2015; October 27, 2015; and April 13, 20, 27 of 2016, constitutes negligence and unprofessional conduct.

47. Thyroid solitary/autonomous nontoxic nodule[9] onset for Patient 1 during Respondent's care was first evident by order on or about November 8, 2017, for ultrasound for chronic hot flashes, which was performed on or about November 15, 2017. The finding was confirmed by biopsy pathology on or about February 5, 2018. Patient 1 had subsequent onset of low thyroid-stimulating hormone (TSH), but normal thyroid hormone levels on or about July 11, 2018, which levels persisted on or about July 16, 2018, as well as on or about November 28, 2018. Previously, on or about February 10, 2016, Respondent reported that Patient 1 had a history of hypothyroidism, but failed to document the basis for that finding. Patient 1's medication list on or about August 8, 2015, did not show that she was being treated for hypothyroidism, and her new patient forms denied that she had an underactive thyroid. Patient 1 also had previous repetitive normal thyroid function blood tests on or about August 11, 2015, through on or about April 16, 2018. However, Patient 1 had pharmacy insurance claims on or about January 2017, through on or about May of 2018, for levothyroxine.[10] Patient 1 received 100 mcg 90 day fills of levothyroxine on or about January 8, 2017, through on or about March 15, 2017, which would have lasted through on or about June 15, 2017. However, Respondent's medication list for Patient 1 shows the earliest levothyroxine prescription for Patient 1 on or about June 21, 2017, but this was not documented in the exam note of that date. Respondent's medication list shows another prescription of levothyroxine for Patient 1 on or about January 24, 2018, when Respondent restarted the supplementation based on Patient 1's symptoms of fatigue and hair loss. Respondent again prescribed levothyroxine for Patient 1 on or about August 20, 2018, for an unsupported diagnosis of hypothyroidism despite recent test data in her chart to the contrary.

48. The standard of care is to clearly document the initiation, change, and cessation of medications, and the medication dose at the time of monitoring test results.

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[9] Thyroid nodules are solid or fluid-filled lumps that form within the thyroid, a small gland located at the base of the neck, just above the breastbone. The great majority of thyroid nodules are not serious and do not cause symptoms. Thyroid cancer accounts for only a small percentage of thyroid nodules.

[10] Levothyroxine is a medication used to treat an underactive thyroid.

49. There are discrepancies between Respondent's prescription record and Patient 1's insurance claim records of prescription fills such that it is not possible to determine Respondent's actions or intent with respect to Patient 1's levothyroxine supplementation. Respondent's intended levothyroxine prescription and Patient 1's compliance are not sufficiently documented at the time thyroid blood tests were drawn to interpret the results among the possibilities of a normal thyroid with unwarranted supplementation, an under-active thyroid that was over supplemented, or an autonomously functioning hormone producing thyroid nodule to explain the several low TSH levels documented for Patient 1. Respondent's inconsistencies and lack of careful documentation of historical prescriptions and assessment of patient compliance to interpret Patient 1's thyroid status constitutes negligence and unprofessional conduct.

PATIENT 2

50. Patient 2 is a female who was approximately 56 years old when she first began seeing Respondent on or about February 1, 2017. Patient 2 was seen by Respondent and/or his staff approximately nine times in approximately fourteen months, from on or about February 1, 2017, through on or about March 2, 2018. At the last of these visits, Patient 2 was approximately 57 years old. Some of Patient 2's medical conditions during the times at issue herein included peripheral arterial disease and varicose veins, hypertension, diabetes type 2 on insulin complicated by neuropathy, and vitamin D deficiency.

Diabetes Management

51. Patient 2 had diabetes type 2, and though she was on insulin, her HgbA1C[11] levels were poorly controlled. On or about February 15, 2017, a HgbA1C level of 15.1 was noted in Patient 2's chart, but the report for that test is missing. On or about March 1, 2018, Patient 2 was taking metformin[12] 1000 mg twice a day, long acting insulin 50-60 units once a day, and short acting insulin 5-20 units before meals. On or about that same date, Patient 2's HgbA1C level was noted as greater than 14 and in-office glucometer values registered as high as 600. Respondent

[11] HgbA1C is a blood test that shows a person's average level of blood sugar over the past 2 to 3 months.

[12] Metformin is an oral diabetes medicine that helps control blood sugar levels. Metformin is used together with diet and exercise to improve blood sugar control in adults with type 2 diabetes mellitus.

did not direct Patient 2 to monitor her glucose levels at home to guide titration of her insulin. Despite marked glucometer elevation, Respondent both failed to attempt to augment Patient 2's long acting insulin dose, by having her take it twice a day, and failed to augment the short acting insulin doses she was taking before meals. He also failed to consider or address whether Patient 2's poorly controlled HgbA1C levels was due to patient noncompliance with medication to justify not increasing insulin doses. Despite an absence of antecedent exam documentation for its initiation, on or about August 11, 2017, Patient 2's Farxiga[13] 5 mg was discontinued.

52. Patient 2 had persistent, consistent, extremely elevated blood sugars with acute glucometer readings in Respondent's office as high as 600, and both of Patient 2's six week average sugar levels reflected in the HgbA1C rendered very high results of 14-15. Respondent's records of medications prescribed for Patient 2 are inconsistent. Overall, Respondent prescribed oral metformin with both 50-60 units long acting insulin and before meal short acting insulin 5-20 units per day, with an inconsistently documented second oral medication Farxiga. Respondent's records do not show inquiry regarding home glucometer readings for any possible labile hypoglycemic reactions limiting indications for increase in insulin dosage. During the 14 months under Respondent's care, there is no documented significant upward adjustment of Patient 2's insulin doses, or alternately, documentation of unpredictable labile periodic low blood sugar swings or absent home monitoring to justify not increasing her insulin usage. Interventions Respondent utilized to care for Patient 2's diabetes are limited to in-office supplemental insulin doses (with a duration of action of a day or less), without any documented longer term out of the office management changes other than changes in the supplement brand, and without any significant changes to the dose of both her long and short acting insulin.

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[13] Farxiga is a brand-name prescription medication. It is approved for different uses in adults with type 2 diabetes or heart failure. In people with type 2 diabetes, it is approved to both improve blood sugar levels when used along with improved diet and exercise and to reduce the risk of hospitalization for heart failure in people with heart disease or risk factors for heart disease. In people with heart failure with or without type 2 diabetes, it's approved to reduce the risk of either hospitalization for heart failure or cardiovascular death in people with reduced ejection fraction (EF). It is not for use in people with type 1 diabetes.

53. The standard of care for diabetes management is to episodically monitor patients' blood sugars and compare the level to the targets for control. When sugars are uncontrolled, an investigation is warranted to see if non-medication, lifestyle factors are to blame, as increasing the dose of a sugar lowering medication, if unbeknownst to the provider the patient has not been taking it, can have catastrophic consequences if the patient does suddenly begin a higher dose with over correction and adverse consequences of hypoglycemia.[14] Absent non-compliance with medications and diet, uncontrolled high sugars are addressed by increasing the dose or number of diabetic medications used until control is achieved.

54. Respondent's failure to order or prescribe any significant augmentation of Patient 2's home insulin regimen or additional home oral or injected diabetes medications in response to repeated, markedly elevated blood sugars from on or about February 15, 2017, to on or about March 1, 2018, constitutes gross negligence.

Vitamin B12 Supplement

55. Though Patient 2 had previously been seen by the NP, Respondent's first visit with her occurred on or about August 10, 2017. Respondent noted that Patient 2 had painful joints, with no inflammation on that date. Patient 2's blood pressure was 141/75, but otherwise her exam was normal. Respondent diagnosed Patient 2 with fatigue, neuropathy, and leg cramps without support by history or exam. Despite this, Respondent administered intramuscular cyanocobalamin (vitamin B12) without first obtaining a lab test, without any recognized indication for the injection, and without any indication why the oral formulation would not be adequate. Subsequently, on or about March 1, 2018, Patient 2's B12 level was elevated at 1481.

56. The standard of care for vitamin B12 supplementation is to reserve its use for patients with confirmed evidence of B12 deficiency either by biochemical testing of blood levels of B12 or its metabolic pathway relatives like methylmalonic acid (MMA), or by such testing in symptomatic patients with B12 deficiency manifestations like pernicious anemia with macroscopic anemia with hypersegmented polymorphonuclear cells, or posterior column neuropathic findings of the lower extremities. The small number of patients with a bonafide

[14] Hypoglycemia is low blood sugar.

indication for B12 supplementation are generally able to successfully supplement B12 orally, and the number with gastric intrinsic co-factor deficiency or terminal ileum disease precluding oral absorption and requiring the cumulative risks of repetitive injection is very small. Most primary care providers would have few if any such patients in their practice. Fatigue is too broad a symptom, much more common in other problems than B12 deficiency, to ever justify the use of B12 supplementation without more objective findings and confirmatory biochemical testing. The discredited placebo use of B12 injections for fatigue or other vague symptoms absent biochemical evidence of deficiency risks a pathologic reinforcement of patient belief in the need for unnecessary repetitive office visits and fraudulent billing to third parties for unindicated services.

57. Respondent's administering of an injection of vitamin B12 to Patient 2, in the absence of both any evidence for impaired oral administration and of documented indication for B12 supplementation by any route at all constitutes negligence.

Corticosteroid Dexamethasone Injection

58. On or about August 10, 2017, Respondent noted that Patient 2 had painful joints, but no inflammation. Patient 2's blood pressure was 141/75, but otherwise her exam was normal. Respondent diagnosed Patient 2 with fatigue, neuropathy, and leg cramps despite a lack of basis via history or exam. Despite the lack of support for his diagnosis, Respondent administered intramuscular corticosteroid dexamethasone to Patient 2 without recognized indication, and in the presence of contraindications of uncontrolled diabetes and hypertension, risking the patient's decompensation.[15]

59. The standard of care for the injection of corticosteroids requires both a valid serious medical problem to warrant these risky medications, and a strong reason, typically of a time sensitive urgent or emergent problem, requiring rapid onset of action for the otherwise widely available cheap and inexpensive oral form. Among the more common indications for such injections are acute shortness of breath in asthma exacerbations, or severe allergic reactions. Risks of corticosteroid use, particularly repetitive use, can include worsening of glucose control

[15] Decompensation is the failure of an organ (especially the liver or heart) to compensate for the functional overload resulting from medication, disease, or other bodily stressor.

in diabetics. The dangers presented by an indicated reason for treatment must exceed the risks to justify its use. The more common diseases warranting their repetitive use are severe chronic obstructive pulmonary disease (COPD), erosive inflammatory arthritis, extensive psoriatic or other steroid responsive skin diseases, or uncommon autoimmune processes threatening organ function. Leg cramps and neuropathy are chronic conditions and not an indication for administration of dexamethasone, which has a duration of action not exceeding one day.

60. Respondent's administration of intramuscular corticosteroid dexamethasone absent any documented indication to Patient 2, whose diabetes was poorly controlled, constitutes gross negligence.

Peripheral Artery Vascular Disease

61. On or about September 8, 2017, Respondent evaluated Patient 2. During that exam, Respondent reviewed and noted Patient 2's August 14, 2017 ankle-brachial index (ABI)[16] results of 1.29 – 1.38, which were normal. Despite the normal ABI results, Respondent diagnosed Patient 2 with peripheral vascular disease (PVD).

62. The standard of care for diagnosing PVD is to obtain a confirmatory imaging or other test modality. An ABI measurement uses an audible or visible output from a pencil like ultrasound probe to measure the sphygmomanometer closing SBP of the brachial artery in the forearm and dorsalis pedis artery below the ankle. Normally, the ankle arterial supply is less easily occluded than that of the upper arm in the normal state and more affected in the diseased narrow state, yielding a normal ankle closing pressure to upper arm closing pressure ratio of greater than 0.9, with lesser values screening positive for possible arteriosclerosis possibly meriting further imaging or intervention.

63. Respondent's diagnosis of PVD, which was unsupported by any documented subjective or objective findings with Patient 2's normal ABI, constitutes negligence.

[16] An ankle-brachial index (ABI) test is a simple way for a doctor to check how well a patient's blood is flowing. They use this test to check for peripheral artery disease (PAD). PAD is a subcategory of peripheral vascular disease (PVD). When a patient has PAD, it means he or she has blockages in the arteries of the arms and legs. This slows blood flow, so the limbs do not get all the oxygen they need. The main difference between PVD and PAD is that PVD occurs in both arteries and veins whereas PAD, as its name implies, only occurs in arteries.

Ketorolac Injection

64. On or about September 22, 2017, Patient 2 was seen by Respondent. Patient 2's chief complaint was noted as pain on hands, and her subjective history noted general joint pains. Respondent diagnosed Patient 2 with claudication[17] and painful varicose veins, and ordered intramuscular ketorolac,[18] an analgesic pain reliever, for her without an obvious acute pain indication.

65. The standard of care for the use of intramuscular analgesic pain relievers is limited to acute exacerbations of pain of moderate or greater severity, or acute complications precluding the oral administration of analgesics. They have no indicated use in the management of chronic pain absent a rare contraindication for oral administration. Ketorolac is a non-opioid analgesic alternative without euphoria or addiction risk, but these safer features do not justify its preferential use for chronic symptoms without inability to take oral medication. It has a similar short, several hour duration of action comparable to common over the counter oral analgesics.

66. Respondent's treatment of Patient 2 with ketorolac injection, absent a documented indication of acute pain, constitutes negligence.

Recordkeeping

67. On or about September 22, 2017, Patient 2 was seen by Respondent. The patient's chart for this date contains inconsistent information. Information that appears to have been entered by a medical assistant, including chief complaint (pain on hands) and vital signs 133/78, is not consistent with information that appears to have been entered by Respondent, including subjective history (general joint pains) and objective vital signs 141/75. The text for both the subjective and objective vital signs is copied verbatim from entries in Patient 2's chart from a visit that occurred two exams prior, on or about August 10, 2017. The September 22, 2017 exam was normal except for a glucometer measurement of 600. Respondent's diagnosis of Patient 2

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[17] Claudication is pain caused by too little blood flow, usually during exercise. Sometimes called intermittent claudication, this condition generally affects the blood vessels in the legs, but claudication can affect the arms, too. At first, one tends to notice the pain only when exercising, but as claudication worsens, the pain may be experienced even when at rest.

[18] Ketorolac is a nonsteroidal anti-inflammatory drug (NSAID). Ketorolac works by reducing hormones that cause inflammation and pain in the body. Ketorolac is used short-term (5 days or less) to treat moderate to severe pain.

with claudication and painful varicose veins is not supported by any history or exam notes. Intramuscular ketorolac was administered without an obvious acute pain indication.

68. The standard of care for medical records documentation is to accurately document the findings of that day's evaluation.

69. The copying and pasting of subjective and objective vital signs from a prior visit, that is not updated for the current visit, constitutes negligence and unprofessional conduct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

70. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence. The circumstances are set forth in paragraphs 9 through 18, 22 through 24, 28 through 34, 51 through 54, and 58 through 60, which are incorporated here by reference as if fully set forth.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

71. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence. The circumstances are set forth in paragraphs 8 through 69, which are incorporated here by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Aiding & Abetting Unlicensed Practice)

72. Respondent is subject to disciplinary action under section 2234 and section 2264, of the Code, in that he engaged in unprofessional conduct by employing and allowing an unlicensed practitioner to engage in the practice of medicine. The circumstances are set forth in paragraphs 9 through 14, which are incorporated here by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Recordkeeping)

73. Respondent is subject to disciplinary action under section 2234 and section 2266, in that he failed to maintain adequate and accurate medical records. The circumstances are set forth

///

in paragraphs 44 through 49 and 67 through 69 above, which are incorporated here by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

74. To determine the degree of discipline, if any, to be imposed on Respondent Carlos A. Alvarez, M.D., Complainant alleges that on or about January 6, 2016, in a prior disciplinary action titled In the Matter of the Accusation Against Carlos A. Alvarez, M.D. before the Medical Board of California, in Case Number 08-2013-234319, Respondent's license was revoked, but revocation was stayed and Respondent was placed on probation for thirty-five (35) months for gross negligence for incomplete and illegible recordkeeping and deficient patient care. That decision is now final and is incorporated by reference 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 Number A 42986, issued to Carlos A. Alvarez, M.D.;

2. Revoking, suspending or denying approval of Carlos A. Alvarez, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Carlos A. Alvarez, 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: FEB 22 2021

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

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Exhibit B

Accusation No. 800-2019-055378

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2320
Facsimile: (559) 445-5106
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Carlos A. Alvarez, M.D.** **6001-B Truxton Ave #220** **Bakersfield, CA 93309** **Physician's and Surgeon's Certificate No. A 42986,** Respondent.	Case No. 800-2019-055378 **ACCUSATION**

PARTIES

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

2. On or about August 15, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number A 42986 to Carlos A. Alvarez, 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 November 30, 2023, unless renewed.

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JURISDICTION

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

STATUTORY PROVISIONS

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:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated

negligent acts.

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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 740 of the Code states:

For purposes of this article, "prescriber" means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

8. Section 741 of the Code states in pertinent part:

(a) Notwithstanding any other law, a prescriber shall do the following:

(1) Offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

(C) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to patients receiving a prescription under paragraph (1) on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression.

(3) Consistent with the existing standard of care, provide education on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

. . .

9. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and

enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

11. Acetaminophen and hydrocodone bitartrate (Vicodin®, Norco®, Lorcet®) is a combination of two medicines used to treat moderate to severe pain. Hydrocodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Hydrocodone has a high potential for abuse. Hydrocodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

12. Alprazolam (Xanaz®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax 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.

13. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

14. Carisoprodol (Soma®) is a muscle relaxant with a known potentiating effect on narcotics. It works by blocking pain sensations between the nerves and the brain. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal

conditions. According to the DEA, Office of Diversion Control, "[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. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions." In December 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance (76 Fed.Reg. 77330 (Dec. 12, 2011).)

15. Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing. It is typically caused by long-term exposure to irritating gases or particulate matter, most often from cigarette smoke. People with COPD are at increased risk of developing heart disease, lung cancer and a variety of other conditions.

16. Ketorolac (Toradol®) is used for the short-term treatment of moderate to severe pain in adults. It is usually used before or after medical procedures or after surgery. Reducing pain helps you recover more comfortably so that you can return to your normal daily activities. This medication is a nonsteroidal anti-inflammatory drug (NSAID). It works by blocking the body's production of certain natural substances that cause inflammation. This effect helps to decrease swelling, pain, or fever. Ketorolac should not be used for mild or long-term painful conditions (such as arthritis).

17. Methocarbamol is used to treat muscle spasms/pain. It is usually used along with rest, physical therapy, and other treatment. It works by helping to relax the muscles. It is not a narcotic, or controlled substance. It is a central nervous system (CNS) depressant and muscle relaxant used to treat muscle spasms, tension, and pain. It may be mistaken for a narcotic due to side effects like drowsiness and dizziness, which can feel like a drug "high."

18. Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as

defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

19. Morphine milligram equivalents (MME) or morphine equivalent dose (MED) is an abbreviation used to evaluate the levels of opioids prescribed to a patient. The Centers for Disease Control recommends avoiding or carefully justifying any dosage greater than 90 MED/day or MME/day.

20. Naloxone hydrochloride (Narcan®/Evizio®) is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. It is an opioid antagonist, meaning that it binds to opioid receptors and can reverse and block the effects of other opioids, such as heroin, morphine, and oxycodone. Administered when a patient is showing signs of opioid overdose, naloxone is a temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical intervention as soon as possible after administering/receiving naloxone. The medication can be given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

21. Neuropathy is a nerve condition that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body. It usually begins in the hands or feet and gets worse over time.

22. Polypharmacy means the simultaneous use of multiple drugs to treat a single ailment or condition. It also can refer to the simultaneous use of multiple drugs by a single patient, for one or more conditions.

23. Temazepam (Restoril®) is a controlled substance used to treat a certain sleep problem (insomnia). It may help one to fall asleep faster, stay asleep longer, and lessen how often they wake-up during the night, to allow for a better night's rest. Temazepam belongs to a class of drugs called benzodiazepines. It acts on your brain to produce a calming effect. Use of this medication is usually limited to short treatment periods of 1 to 2 weeks or less.

24. Tramadol (Ultram®, Ultracet®) an opioid analgesic, 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. Tramadol has the potential for abuse. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

BACKGROUND & FACTUAL ALLEGATIONS

Patient A[1]

25. Patient A, a female, was under Respondent's care for many years. In or about August of 2015, Patient A was 71 years old. From in or about August of 2015, through in or about December of 2021, Respondent and/or his staff saw Patient A for numerous acute and chronic issues, including chronic back pain, anxiety/depression, breathing difficulties (COPD vs asthma vs chronic cough), insomnia, and bladder cancer, among others. Respondent managed Patient A's back pain with narcotics and muscle relaxants. During flares of Patient A's pain, she received Toradol injections from Respondent. Respondent subsequently added Tramadol to Patient A's medication regimen. Patient A's cough was controlled with codeine syrup and her insomnia with prescription sleep medication (Ambien and/or temazepam).

26. According to the CURES report, during the period of in or around June of 2019, through in or around August of 2021, Patient A filled the following prescriptions of controlled substances which Respondent prescribed:

Patient A						
Date Filled	Drug Name	Form	Strength	Qty	Days Supply	Refill#
2019-07-16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2019-08-09	TEMAZEPAM	CAP	30 MG	30	30	0
2019-08-09	TRAMADOL HCL	TAB	50 MG	120	30	0
2019-08-16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2019-09-04	CARISOPRODOL	TAB	350 MG	120	30	0
2019-10-03	CARISOPRODOL	TAB	350 MG	120	30	0
2019-10-06	TEMAZEPAM	CAP	30 MG	30	30	0
2019-10-07	TRAMADOL HCL	TAB	50 MG	120	30	0
2019-10-14	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0

[1] The patients' names are redacted to protect their privacy.

2019-11-04	CARISOPRODOL	TAB	350 MG	120	30	0
2019-11-05	TEMAZEPAM	CAP	30 MG	30	30	0
2019-11-07	TRAMADOL HCL	TAB	50 MG	120	30	0
2019-11-13	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2019-12-05	CARISOPRODOL	TAB	350 MG	120	30	0
2019-12-06	TEMAZEPAM	CAP	30 MG	30	30	0
2019-12-06	TRAMADOL HCL	TAB	50 MG	120	30	0
2019-12-12	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-01-04	CARISOPRODOL	TAB	350 MG	120	30	1
2020-01-04	TEMAZEPAM	CAP	30 MG	30	30	1
2020-01-04	TRAMADOL HCL	TAB	50 MG	120	30	1
2020-02-02	CARISOPRODOL	TAB	350 MG	120	30	2
2020-02-02	TEMAZEPAM	CAP	30 MG	30	30	2
2020-02-02	TRAMADOL HCL	TAB	50 MG	120	30	2
2020-02-08	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-03-05	CARISOPRODOL	TAB	350 MG	120	30	3
2020-03-05	TEMAZEPAM	CAP	30 MG	30	30	3
2020-03-05	TRAMADOL HCL	TAB	50 MG	120	30	3
2020-03-12	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-04-13	CARISOPRODOL	TAB	350 MG	120	30	0
2020-04-13	TEMAZEPAM	CAP	30 MG	30	30	0
2020-04-13	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-04-14	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	0
2020-05-12	CARISOPRODOL	TAB	350 MG	120	30	0
2020-05-12	TEMAZEPAM	CAP	30 MG	30	30	0
2020-05-12	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-05-13	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-06-11	CARISOPRODOL	TAB	350 MG	120	30	0
2020-06-11	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-06-11	TEMAZEPAM	CAP	30 MG	30	30	0
2020-06-11	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-07-11	CARISOPRODOL	TAB	350 MG	120	30	0
2020-07-11	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-07-11	TEMAZEPAM	CAP	30 MG	30	30	0
2020-07-11	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-08-11	CARISOPRODOL	TAB	350 MG	120	30	0
2020-08-11	TEMAZEPAM	CAP	30 MG	30	30	0

2020-08-11	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-08-13	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-10-13	CARISOPRODOL	TAB	350 MG	120	30	0
2020-10-13	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-10-13	TEMAZEPAM	CAP	30 MG	30	30	0
2020-10-13	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-12-14	CARISOPRODOL	TAB	350 MG	120	30	0
2020-12-14	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2020-12-14	TRAMADOL HCL	TAB	50 MG	120	30	0
2020-12-14	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	0
2021-01-14	CARISOPRODOL	TAB	350 MG	120	30	0
2021-01-14	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2021-01-14	TRAMADOL HCL	TAB	50 MG	120	30	0
2021-01-15	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	0
2021-05-11	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	0
2021-05-14	CARISOPRODOL	TAB	350 MG	120	30	0
2021-05-14	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2021-05-14	TRAMADOL HCL	TAB	50 MG	120	30	0
2021-06-15	CARISOPRODOL	TAB	350 MG	120	30	0
2021-06-15	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	0
2021-06-15	TRAMADOL HCL	TAB	50 MG	120	30	0
2021-06-15	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	0

27. Naloxone hydrochloride (Narcan®/Evizio®) was not prescribed for Patient A at any time between in or about August of 2015, through in or about December of 2021.

Patient B

28. Patient B, a male, was under Respondent's care for many years. In or about August of 2015, Patient B was 57 years old. From in or about August of 2015, through in or about December of 2021, Patient B was seen by Respondent and/or his staff for a variety of acute and chronic issues including diabetes, diabetic neuropathy, anxiety, and hypertension. Patient B's neuropathy was severe enough to require treatment with methadone, as other therapies reportedly

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had failed. Patient B was seen monthly for his chronic pain and anxiety, with additional periodic visits when acute issues arose.

29. According to the CURES report, during the period of in or around June of 2019, through in or around August of 2021, Patient B filled the following prescriptions of controlled substances which Respondent prescribed:

Patient B						
Date Filled	Drug Name	Form	Strength	Qty	Days Supply	Refill#
2019-06-22	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2019-07-12	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2019-07-12	METHADONE HCL	TAB	10 MG	90	30	0
2019-07-15	VYVANSE	CAP	60 MG	30	30	0
2019-07-17	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2019-08-12	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2019-08-12	METHADONE HCL	TAB	10 MG	90	30	0
2019-08-12	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2019-10-08	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2019-10-08	METHADONE HCL	TAB	10 MG	90	30	0
2019-10-08	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2019-11-02	ALPRAZOLAM	TAB	0.5 MG	30	30	0
2019-11-02	METHADONE HCL	TAB	10 MG	90	30	0
2019-11-02	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2019-12-10	ALPRAZOLAM	TAB	0.5 MG	30	30	0
2019-12-10	METHADONE HCL	TAB	10 MG	90	30	0
2019-12-10	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-01-09	METHADONE HCL	TAB	10 MG	90	30	0
2020-01-10	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-01-15	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-02-07	METHADONE HCL	TAB	10 MG	90	30	0
2020-02-26	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-03-24	ALPRAZOLAM	TAB	0.5 MG	30	30	0
2020-03-24	METHADONE HCL	TAB	10 MG	90	30	0
2020-03-24	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-04-24	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-04-24	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-05-01	METHADONE HCL	TAB	10 MG	90	30	0
2020-05-25	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-05-25	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-06-08	METHADONE HCL	TAB	10 MG	90	30	0
2020-06-25	ALPRAZOLAM	TAB	0.5 MG	60	30	0

2020-06-25	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-07-07	METHADONE HCL	TAB	10 MG	90	30	0
2020-07-23	ALPRAZOLAM	TAB	0.5 MG	60	30	1
2020-07-23	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-08-04	METHADONE HCL	TAB	10 MG	90	30	0
2020-08-19	ALPRAZOLAM	TAB	0.5 MG	60	30	2
2020-08-23	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-09-08	METHADONE HCL	TAB	10 MG	90	30	0
2020-09-22	ALPRAZOLAM	TAB	0.5 MG	30	30	0
2020-09-22	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-10-12	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-10-20	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-11-03	METHADONE HCL	TAB	10 MG	90	30	0
2020-11-09	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-11-18	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-11-30	METHADONE HCL	TAB	10 MG	90	30	0
2020-12-11	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2020-12-15	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2020-12-29	METHADONE HCL	TAB	10 MG	90	30	0
2021-01-09	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2021-01-26	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2021-02-04	METHADONE HCL	TAB	10 MG	90	30	0
2021-02-06	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2021-03-01	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2021-05-04	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2021-05-04	METHADONE HCL	TAB	10 MG	90	30	0
2021-05-27	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2021-07-09	ALPRAZOLAM	TAB	0.5 MG	60	30	0
2021-07-29	METHADONE HCL	TAB	10 MG	90	30	0
2021-07-29	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	0
2021-08-06	ALPRAZOLAM	TAB	0.5 MG	60	30	0

30. Naloxone hydrochloride (Narcan®/Evizio®) was not prescribed for Patient B at any time between in or about August of 2015, through in or about December of 2021.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

31. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence. The circumstances set forth in paragraphs 25 through 30 are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

32. The standard of care in the community closely parallels the guidelines issued by the Medical Board of California for the management of patients with acute and chronic pain. These guidelines were formally released in or around late 2014, and were based on widely accepted best practices already in place. Prior to this, less attention was paid to total narcotic dose (now commonly expressed in morphine milligram equivalents or MME) and more focus was placed on dose stability and compliance. The dangers of polypharmacy, most notably with benzodiazepines and opiates, were also less stressed in these previous years, but were well established by the time the guidelines came out.

History & Physical Exam of Chronic Pain Patients

33. The standard of care requires a history detailed enough to assess the patient's complaints and level of functioning in their current state. Medication compliance and efficacy should be assessed at each visit, with special attention paid to "red flag" findings such as missed appointments, early refills, etc. Questioning about medication side effects should occur periodically. The physical exam should be comprehensive, covering not only the areas of pain but also include the various organ systems affected by the medications. Head-to-toe physicals are not required at each visit, but comprehensive exams should occur periodically.

Patient A

34. Respondent or a mid-level provider under his supervision saw Patient A approximately every month between in or around August of 2015, through in or around December of 2021. No formal history describing Patient A's back pain was documented in the record during this time. The etiology of her chronic pain was not clearly documented in the patient's chart, though apparently it was due to severe arthritis. Likewise, her level of functioning was also not clearly documented, though the most recent notes describe the patient as "wheelchair bound." Additionally, Patient A's response to treatment was often minimally documented, if documented at all. Notes in Patient A's chart regarding pain often contradicted the information entered in the corresponding table of vital signs. In addition, physical findings were very sparse, with comments such as "back tenderness" or "scoliosis" often being the only entry. On many visits no back exam was performed or documented. Respondent's knowledge of Patient A and

her health conditions were not reflected in the medical records. Respondent's failure to perform and document adequate history and physical exams on Patient A constitute negligence.

Patient B

35. The extent and severity of Patient B's neuropathy between in or around August of 2015, through in or around December of 2021, cannot be fully assessed. Patient B's pain was severe enough that medication was indicated, and non-narcotic therapies had failed. There was little in the way of functional assessment documented, though some statements such as "use can (sic) for ambulation due to neuropathy" were variously noted. Patient B's complaints of pain were occasionally recorded, but the severity of the pain and its effect on his functioning were not assessed.

36. Physical examination of Patient B's legs was absent on most visits, though occasionally a statement such as "FROM, no deformities" or "decreased ROM related to bilateral feet pain" was noted. Patient B had yearly physicals, yet even on these more intensive visits, documentation regarding Patient B's neuropathy was limited. Neurologic assessment of Patient B's legs occurred on occasion, but findings were inconsistent. On or about April 13, 2018, "decreased sensation to pinprick and soft touch" was recorded, yet in or about two months later "sensation to pinprick and light touch intact" was recorded. These issues included visits where Patient B was seen by Respondent or one of his mid-level providers. Respondent's failure to perform and document adequate history and physical exams on Patient B constitute negligence.

Informed Consent

37. The standard of care states the physician should discuss the risks and benefits of the use of controlled substances with the patient. Though formal consent forms are almost never required, pain contracts, when utilized, can provide written clarity for the patient regarding the role and rationale for the use of controlled substances. The patient should be advised about potential side effects and interactions with alcohol, marijuana, and illicit drugs.

Patient A

38. The informed consent discussion is especially important given Patient A's use of multiple controlled medications, including narcotics, carisoprodol, and benzodiazepines.

Increased risks with concomitant use of narcotics and sedatives are well known, and specific precautions were given to providers in 2014 via the Medical Board's pain management guidelines. Respondent failed to engage in and document specific discussions of the risks of polypharmacy with Patient A. On or about April 20, 2017, Respondent's staff discussed dependence with Patient A. On or about May 21, 2019, Respondent's staff discussed the risk of death with hydrocodone with Patient A, but this was done only because Patient A became upset about her dose being reduced. The detail and depth of either of these discussions is unclear from the chart. Patient A was on one of the most dangerous combinations of controlled medications, and was likely unaware of the risks. The generic statements contained in Patient A's record regarding review of side effects and risks are insufficient. Respondent's lack of engaging in and documenting informed consent discussions with Patient A while prescribing controlled substances for her constitutes negligence.

Patient B

39. The informed consent discussion is especially important given Patient B's use of multiple controlled medications, including narcotics and benzodiazepines. Increased risks with concomitant use of narcotics and sedatives are well known, and specific precautions were given to providers in 2014 via the Medical Board's pain management guidelines. The use of methadone in the doses given (240 MME/day) placed Patient B in a high-risk group, warranting a detailed discussion of the risks and benefits of this medication. The fact that Patient B was also on a benzodiazepine greatly increased the risks, further reinforcing the need for detailed consent discussions. The generic statements contained in Patient B's record regarding review of side effects and risks are insufficient. Respondent's lack of engaging in and documenting informed consent discussions with Patient B while prescribing controlled substances for him constitutes negligence.

Periodic Review & Consultation

40. The standard of care requires physicians to periodically review and document the patient's treatment and progress. Continued use of various treatments, including controlled substances, depends on progress toward stated goals. Ineffective or minimally effective

medications should be weaned and other therapies considered. Special attention needs to be paid to patient compliance, but even for compliant patients simply continuing medication year after year without review falls below the standard of care. Specialty consultation should also be considered periodically, depending on the nature of the patient's condition and progress with the stated plan.

Patient A

41. Between in or around August of 2015, through in or around December of 2021, Patient A was seen approximately monthly, but her chronic pain was never addressed beyond refilling her medication. Numerous acute, non-pain related issues were documented and addressed in reasonable detail, but her chronic pain was not. Beginning in or about August of 2015, Patient A's records reflect a back pain regimen that was not ideal, namely a narcotic (hydrocodone - 40 MME/day) and carisoprodol 4 times/day. Given that Patient A was also using codeine syrup up to 3 times/day, her actual MME was even higher. Carisoprodol is only indicated for short-term use, and it is metabolized to a barbiturate, making its use with narcotics problematic. Hence, even though Patient A may have been stable on this regimen for some time, changes should have been considered early on in her treatment.

42. On several occasions between in or around August of 2015, through in or around December of 2021, the chart mentions referral of Patient A to a pain specialist. The most detailed note in this regard was entered by a medical student in or around November of 2018, stating that Patient A reported she had not and did not want to see a pain specialist. Respondent's understanding was that the pain management specialist "did not want to deal" with Patient A. Given that Patient A apparently only wanted to receive her care from Respondent, it fell upon him alone to review and adjust her treatment.

43. There was one documented attempt, between in or around August of 2015, through in or around December of 2021, to wean Patient A to a lower dose of narcotics, but it was short lived. No attempt was made to wean Patient A's use of carisoprodol for years either, though it was changed to methacarbamol on or about October 12, 2021. In addition, no decrease in dosage of either of these medications was made when temazepam was subsequently prescribed for

Patient A's insomnia. This addition of a benzodiazepine to the regimen significantly increased the risks, and should have prompted further review. Further, it is unclear if the benefits of temazepam use outweighed the risk for Patient A.

44. On occasion a new medication would be tried (such as gabapentin and tramadol), but assessment and documentation about the medication's effectiveness was minimal or absent. Patient A's use of tramadol is of particular concern because it is essentially a narcotic analog and combining it with hydrocodone increases the risk of respiratory depression, seizure, etc. Benefit to Patient A from tramadol was not clearly assessed or documented. Despite this, it was refilled over and over. If tramadol was helpful, then tapering of one of the other medications Patient A was taking could have been considered. If it was not helping, then tramadol itself should have been stopped. Any change in Patient A's pain pattern was not clearly assessed or documented and tramadol just became part of the regimen refilled each month.

45. Respondent's failure to conduct periodic reviews and to refer Patient A for consultation constitutes negligence.

Patient B

46. Between in or around August of 2015, through in or around December of 2021, Patient B was seen at least monthly by Respondent or a member of his staff. The visits were mainly to refill his medications, address new acute issues, and manage his chronic conditions. There was little documentation about Patient B's neuropathy recorded during these visits. Although occasional statements about the medications helping were noted, no clear picture of Patient B's level of functioning or response to treatment was clearly assessed or documented. Acute problems were dealt with appropriately, but Patient B's chronic pain appears to have been addressed and managed simply by refilling his medications.

47. If Patient B was doing well with the 30 mg regimen of methadone for years (as evidenced by the 0 level of pain frequently recorded during the visits) then some form of tapering should have been considered. Patient B's MME was quite high (240) even though the total milligram dose of the methadone was low. Regardless, Respondent did not calculate Patient B's MME to be aware of both how high his MME dose was and the accompanying increased risk of

death. The risks to Patient B were further increased by the use of alprazolam for his anxiety. Even if Patient B's pain was not controlled by any non-narcotic option, a lower dose may have provided some margin of safety. Between in or around August of 2015, through in or around December of 2021, no specialist consultations were requested regarding Patient B's neuropathy. In or around that same timeframe, once a regimen was found that seemed to control Patient B's pain from his neuropathy, Patient B was simply left on the regimen for years despite the risks. The lack of meaningful assessment or documentation by Respondent or his staff regarding periodic review of the treatment provided constitutes negligence.

Treatment of Anxiety – Patient B

48. The standard of care for prescribing controlled substances depends on numerous factors, including the nature of the substance, the goals of treatment, patient variables, etc. Respondent prescribed alprazolam for Patient B's anxiety. In this setting the standard of care requires reasonable rationale for using a controlled substance, informed consent for use from the patient, periodic monitoring for efficacy and side effects, limiting polypharmacy, and periodic re-evaluation regarding continued use.

49. Although alprazolam is commonly used to treat anxiety and has an FDA approved indication for this purpose, its use remains problematic. There is high potential for abuse and respiratory depression, especially when combined with opioids, making it a suboptimal choice for the long-term management of anxiety in most patients.

50. Patient B was on alprazolam since at least in or around 2015. The medication was prescribed for anxiety, but the details regarding this diagnosis are unclear from Respondent's records. The overwhelming majority of Respondent's records contain no psychiatric review of systems or evaluation. In mid-level provider notes from in or around 2019 "+ anxiety" and "feeling anxious" were documented, but no details were provided. The most detailed of Respondent's own note, from on or about February 24, 2020, is not detailed enough to ascertain a clear picture of Patient B's level of anxiety or response to treatment. Respondent failed to specifically document the effectiveness of alprazolam on Patient B's anxiety.

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51. Given that Patient B was apparently narcotic dependent due to his neuropathy, Respondent should have evaluated Patient B's ongoing use of alprazolam in detail. Respondent failed to document a discussion of the risks of using alprazolam with Patient B. Between in or around 2015 and in or around 2019, Patient B apparently remained stable on his dose of alprazolam, though its effectiveness was otherwise not ascertained. In or about August of 2019, Patient B's wife died, triggering a flare of his anxiety. In or around this time, Patient B was referred for psychiatric treatment and Lexapro was added to his regimen. However, Patient B stopped Lexapro after only three days, reportedly due to its lack of effectiveness. Respondent did not adjust Patient B's alprazolam dose or its effectiveness, and did not account for his psychiatric treatment.

52. Respondent's ongoing use of alprazolam to treat Patient B's anxiety coupled with the failure to periodically assess Patient B's response, and the lack of risk discussion, constitutes negligence.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

53. Respondent is subject to disciplinary action under section 2234, subdivision (a), in that he violated section 741 by failing to offer a prescription for naloxone hydrochloride or another approved drug to Patient A and Patient B when an opioid medication was prescribed for them concurrently with a prescription for benzodiazepine. The circumstances are set forth in paragraphs 25 through 52, which are incorporated here by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Recordkeeping)

54. Respondent is subject to disciplinary action under section 2234 and section 2266, in that he failed to maintain adequate and accurate medical records. The circumstances are set forth in paragraphs 25 through 52, which are incorporated here by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

55. To determine the degree of discipline, if any, to be imposed on Respondent Carlos A. Alvarez, M.D., Complainant alleges that on or about January 6, 2016, in a prior disciplinary

action titled In the Matter of the Accusation Against Carlos A. Alvarez, M.D. before the Medical Board of California, in Case Number 08-2013-234319, Respondent's license was revoked, but revocation was stayed and Respondent was placed on probation for thirty-five (35) months for gross negligence for incomplete and illegible recordkeeping and deficient patient care. That decision is now final and is incorporated by reference 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 Number A 42986, issued to Respondent Carlos A. Alvarez, M.D.;

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

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

4. Ordering Respondent Carlos A. Alvarez, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: APR 29 2022

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

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