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

In the Matter of the Accusation
Against:

Wolfram Richard Forster, M.D.  Case No. 8002014004551

Respondent

DECISION AND ORDER

The attached Stipulated Surrender 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 October 27, 2016.

IT IS SO ORDERED October 20, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

WOLFRAM FORSTER, M.D.
5540 Caminito Herminia
La Jolla, CA 92037-7221

Physician’s and Surgeon’s Certificate
No. C 50765,

Respondent.

Case No. 800-2014-004551

STIPULATED SURRENDER AND
DISCIPLINARY ORDER

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Lori Jean Forcucci, Deputy Attorney General.

2. Respondent Wolfram Forster, M.D. (Respondent) has elected to represent himself in the above-captioned matter, and has chosen not to exercise his right to be represented by legal counsel at his own expense in this proceeding.

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3. On or about February 6, 2002, the Medical Board of California issued Physician’s and Surgeon’s Certificate No. C 50765 to Respondent. Physician’s and Surgeon’s Certificate No. C 50765 was in full force and effect at all times relevant to the charges and allegations brought in Accusation No. 800-2014-004551 and will expire on October 31, 2017, unless renewed.

JURISDICTION

4. On August 26, 2016, Accusation No. 800-2014-004551 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against respondent. A true and correct copy of Accusation No. 800-2014-004551 and all other statutorily required documents were properly served on Respondent by certified mail at his address of record on file with the Board, which was and is 5540 Caminito Herminia La Jolla, CA 92037-7221. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2014-004551 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and fully understands the charges and allegations in Accusation No. 800-2014-004551. Respondent also has carefully read, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in Accusation No. 800-2014-004551; the right to be represented by counsel; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

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8. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2014-004551, and agrees that he has thereby subjected his Physician’s and Surgeon’s Certificate No. C 50765 to disciplinary action and hereby surrenders his Physician’s and Surgeon’s Certificate No. C 50765 for the Board’s formal acceptance.

9. Respondent further agrees that if he ever petitions for reinstatement of his Physician’s and Surgeon’s Certificate No. C 50765, or if an accusation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2014-004551 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 or elsewhere.

10. Respondent understands that by signing this stipulation he enables the Executive Director of the Medical Board to issue an Order accepting the surrender of his Physician’s and Surgeon’s Certificate No. C 50765, on behalf of the Board, without further notice to, or opportunity to be heard by, Respondent.

**CONTINGENCY**

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board “shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license.”

12. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to

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rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General’s Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

15. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that copies shall have the same force and effect as originals.
16. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Medical Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order on behalf of the Board:

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 50765, issued to Respondent Wolfram Forster, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. C 50765 and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement of a revoked license. Respondent must comply with all laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2014-004551, separately and severally, shall be deemed to be true, correct and fully admitted by Respondent when the Board determines whether to grant or deny the petition.

5. 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 agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2014-004551, separately and severally, shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.
ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order. I fully understand the terms and conditions and other matters contained herein. I understand the stipulation and the effect it will have on my Physician’s and Surgeon’s Certificate No. C 50765. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Disciplinary Order of the Medical Board.

DATED: 10-02-16

WOLFRAM FORSTER, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California, Department of Consumer Affairs.

Dated: 10-7-16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

LORI JEAN FORCUCCI
Deputy Attorney General
Attorneys for Complainant
In the Matter of the Accusation Against: WOLFRAM R. FORSTER, M.D.  
5540 Caminito Herminia  
La Jolla, CA 92037-7221  
Physician's and Surgeon's Certificate No. C 50765,  

Respondent.

Complainant alleges:

PARTIES

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

2. On or about February 6, 2002, the Medical Board issued Physician’s and Surgeon’s Certificate No. C 50765 to respondent Wolfram R. Forster, M.D. (Respondent). Physician’s and Surgeon’s Certificate No. C 50765 was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.
3. On or about June 14, 2016, Complainant filed a Petition for Ex Parte Interim Suspension Order, Case No. 800-2014-004551, pursuant to Government Code section 11529, alleging that Respondent had been found (1) to have a personality disorder/mental disorder that impairs his ability to practice in a safe manner, to represent threat of serious injury to the public under Business and Professions Code (Code) section 822; and (2) to have committed acts of unprofessional conduct under section 2234, subdivisions (b) and (e) of the Code.

4. On or about June 24, 2016, the parties signed a Stipulation of the Parties Re: Interim Order Imposing Practice Restriction and Order, and an Interim Order was signed, providing that:

   “Based on the foregoing stipulations and agreements, an Interim Order is hereby issued immediately restricting Physician’s and Surgeon’s Certificate No. C 50765 heretofore issued by the Medical Board of California to Respondent Wolfram Forster, M.D., and, accordingly, Respondent is hereby immediately prohibited from prescribing any and all controlled substances as defined in the California Controlled Substances Act under Schedules I, II, III, IV and V, including Suboxone, in the State of California pending further order from the Medical Board of California. The Interim Order issued in Case No. 2016040026 shall remain in effect until the charges and allegations in the to-be-filed Accusation against Respondent are fully resolved. Subsequent to the filing of the Accusation against Respondent, a Request to Set form will be filed with the Office of Administrative Hearings (OAH) requesting a hearing during the time period on or after October 19, 2016, and on or before November 18, 2016, at a time convenient to the OAH and the parties.”

5. 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.

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

7. Section 822 of the Code states:

"If a licensing agency determines that its licentiate’s ability to practice his or
her profession is impaired because the licentiate is mentally ill or physically ill
affecting competency, the licensing agency may take action by any one of the
following methods:

“(a) Revoking the licentiate’s certificate of license.
“(b) Suspending the licentiate’s right to practice.
“(c) Placing the licentiate on probation.
“(d) Taking any other action in relation to the licentiate as the licensing agency
in its discretion deems proper.

“...”

8. Section 824 of the Code provides:

"The licensing agency may proceed against a licentiate under either Section
820, or 822, or under both sections."

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

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

“..."

“(b) Gross negligence.
“(c) Repeated negligent acts.
“(d) Incompetence.
“(e) The commission of any act involving dishonesty or corruption that is
substantially related to the qualifications, functions and duties of a physician and
surgeon."
10. Section 725 of the Code states, in pertinent part:

   "(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) ...

   "(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."

11. Unprofessional conduct under Business and Professions Code section 2234 is conduct 
    which breaches the rules or ethical code of the medical profession, or conduct which is 
    unbecoming to a member in good standing of the medical profession, and which demonstrates an 
    unfitness to practice medicine. (Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 
    575.)

12. Section 2266 of the Code states, in pertinent part:

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

FIRST CAUSE FOR DISCIPLINE

   (Gross Negligence)

13. Respondent has subjected his Physician’s and Surgeon’s Certificate No. C 50765 to 
    discipline under sections 2227 and 2234, as defined by 2234, subdivision (b) of the Code, in that
he committed gross negligence in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y. and V.B. as more particularly alleged hereinafter:

Patient R.W.

14. On or about November 13, 2013, patient R.W., a 23 year old male, first presented to Respondent for reported chronic pain in his left wrist. Respondent noted that patient R.W. was in excellent general health, that he had some pain in the left wrist, but no other deformity or diminished range of motion.

15. On or about November 26, 2013, patient R.W. returned to see Respondent. Patient R.W. did not enter into a pain management agreement with Respondent for prevention of diversion. Respondent prescribed Oxycodone,\(^1\) 20 mg 120 tablets, and Ambien,\(^2\) 5 mg 30 tablets.

16. On or about December 18, 2013, patient R.W. returned to see Respondent. (a) Respondent discontinued patient R.W.'s prescription of Ambien, but prescribed Norco\(^3\) 7.5/325 three times per day, representing 22.5 mg MED\(^4\), for a total of 144.5 mg MED per day. Respondent did not assess risks and/or benefits of diversion, discuss goals and activities with patient R.W. or obtain informed consent based on such a discussion. Patient R.W. provided a biological fluid sample of urine that tested positive for opioids, but Respondent failed to clinically assess whether there was any relevance to patient R.W.'s positive urinalysis test result.

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1 Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone, 20 mg, taken four times per day, is equivalent to a 120 mg Morphine Equivalent Dose (MED) [see footnote 4, below.]

2 Ambien is a brand name for zolpidem, 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.

3 Norco (an opioid) is a brand name for acetaminophen and hydrocodone bilartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

4 A MED is a numerical standard against which most opioids can be compared, yielding an "apples to apples" comparison of each medication's potency. Morphine is used as the basis for comparison because it is considered the gold standard for the treatment of pain. Knowing the MED helps determine if the doses are excessive and is useful if converting from one opioid to another.
(b) Respondent did not document patient R.W.'s medical records with a reason for the addition of Norco. Respondent did not document a discussion of goals and activities, or risks and/or benefits of treatment with prescribed medications in patient R.W.'s medical records.

17. On or about January 15, 2014, patient R.W. returned to see Respondent.
   (a) Respondent did not perform a physical examination of patient R.W., and did not order a further urinalysis. Respondent renewed patient R.W.'s prescriptions.
   (b) Respondent did not document a physical examination or an order for urinalysis in patient R.W.'s medical records.

18. On or about February 12, 2014, patient R.W. returned to see Respondent.
   (a) Respondent prescribed an increased amount of Norco for patient R.W., increasing the prescription to 4 times per day, for a total MED of 152 mg per day.
   (b) Respondent did not document a reason for the increased dosage of Norco in patient R.W.'s medical records.


20. On or about April 11, 2014, patient R.W. returned to see Respondent.
   (a) Respondent did not discuss diversion or other negative side effects of the medications with patient R.W. Respondent renewed patient R.W.'s prescriptions.
   (b) Respondent did not document a discussion regarding diversion or other negative side effects of the medications in patient R.W.'s medical records.

21. On or about April 21, 2014, Respondent noted a telephone call with patient R.W.'s mother, who was a physician in the State of Colorado. She stated that patient R.W. did not have chronic pain, and expressed concern about the high dosage of opioids that patient R.W. was receiving. Respondent asked patient R.W.'s mother if he could discuss her call with patient R.W., instead of asking patient R.W. if he could discuss the patient's protected health information with the patient's mother.
Patient S.W.

22. On or about January 24, 2013, patient S.W., a female, first presented to Respondent.

   (a) Patient S.W.’s medical records included a form that reported intraductal breast cancer, and irradiation had been scheduled. Previous doctor’s visits indicated frequent low back pain with an unknown etiology; frequent migraine headaches (for which she took morphine sulfate, which was no longer effective); and previous treatment for anxiety. Respondent did not perform a physical examination of patient S.W., assess risks and/or benefits of diversion, discuss goals and activities her, or obtain informed consent based on such a discussion, order a urinalysis test, assess her for diversion, or check the Controlled Substance Utilization Review and Evaluation System (CURES). Respondent prescribed Dilaudid 8 mg 60 tablets, Xanax 2/5 mg 45 tablets, and Paxil (paroxetine) 20 mg 30 tablets.

   (b) Respondent did not document a physical examination, a discussion of risks and/or benefits of diversion, goals and activities, or informed consent based on such a discussion, assess for diversion, order a urinalysis or a CURES report, in patient S.W.’s medical records.

23. On or about February 8, 2013, patient S.W. returned to see Respondent.

   (a) Respondent did not perform a physical examination of patient S.W. She reported that the Dilaudid was working well, but she could not tolerate Xanax. Respondent

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5 Dilaudid (an opioid) is a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

6 Xanax (alprazolam) of the benzodiazepine class is a brand name for alprazolam, 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.

7 Paxil (paroxetine) is an antidepressant, a selective serotonin reuptake inhibitor (SSRI).
prescribed Klonopin (clonazepam), increased Dilaudid 8 mg to 120 tablets, and increased Paxil (paroxetine) 20 mg to 60 tablets. Respondent did not order a urinalysis test or assess patient S.W. for diversion.

(b) Respondent did not document a urinalysis test or assessment for diversion in patient S.W.'s medical records.

24. On or about March 8, 2013, patient S.W. returned to see Respondent.

(a) Patient S.W. reported that the Dilaudid did not last long enough. Respondent prescribed Oxycodone HCL 30 mg 120 tablets, and clonazepam 0.5 mg 90 tablets. Respondent documented that because Medi-Cal does not pay for more than 90 tablets, he wrote two prescriptions. Respondent did not discuss the risks and/or benefits of mixing benzodiazepines with high dose opioids, obtain informed consent, order a urinalysis test, or assess patient S.W. for diversion.

(b) Respondent did not document the reason for increasing patient S.W.'s dosage of opiates, did not document an order for a urinalysis test, or assessment for diversion in patient S.W.'s medical records.

25. On or about April 3, 2013, patient S.W. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient S.W., did not order a urinalysis test, or assess her for diversion. Respondent renewed patient S.W.'s prescriptions.

(b) Respondent did not document an order for a urinalysis test or assessment for diversion in patient S.W.'s medical records.

26. On or about May 1, 2013, patient S.W. returned to see Respondent.

(a) Respondent changed patient S.W.'s Paxil prescription to Effexor 2.5 mg 30 tablets, at the request of the patient's oncologist, and renewed her prescriptions of

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8 Klonopin (clonazepam), a benzodiazepine, 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.

9 Effexor is an antidepressant, a selective serotonin and norepinephrine reuptake inhibitor.
Oxycodone 30 mg 90 tablets, and clonazepam 0.5 mg 90 tablets. Respondent did not order
a urinalysis test on patient S.W. or assess her for diversion.

(b) Respondent did not document a urinalysis test or assessment for diversion in
patient S.W.'s medical records.

27. On or about May 29, 2013, patient S.W. returned to see Respondent.

(a) Respondent renewed patient S.W.'s prescriptions, including clonazepam
(Klonopin) 0.5 mg 90 tablets, and Oxycodone 30 mg 30 tablets plus a second prescription
for 30 mg 90 tablets, and Effexor 25 mg 30 tablets. Patient S.W. signed a pain management
contract with Respondent. Respondent did not order a urinalysis test on patient S.W. or
assess her for diversion.

(b) Respondent did not document a urinalysis test or assessment for diversion in
patient S.W.'s medical records.

28. On or about June 26, 2013, patient S.W. returned to see Respondent.

(a) A note indicated that patient S.W.'s oncologist was concerned about patient
S.W.'s blood pressure and tachycardia and that she was scheduled for an EKG and
echocardiogram. Respondent performed no heart or lung examination on patient S.W., did
not order a urinalysis test on patient S.W. or assess her for diversion. Respondent renewed
patient S.W.'s prescriptions.

(b) Respondent documented no physical examination, no urinalysis test or
assessment for diversion in patient S.W.'s medical records.

29. On or about July 23, 2013, patient S.W. returned to see Respondent.

(a) Respondent did not order a urinalysis test on patient S.W. or assess her for
diversion. Respondent renewed patient S.W.'s medication prescriptions.

(b) Respondent did not document a urinalysis test or assessment for diversion in
patient S.W.'s medical records.

30. On or about August 8, 2013, patient S.W. returned to see Respondent. Respondent
noted that patient S.W. would be out of town at the time that her medications would be renewed.
He noted he would renew the prescription in seven days.
31. On or about August 27, 2013, patient S.W. returned to see Respondent. Respondent renewed her prescriptions.

32. On or about September 25, 2013, patient S.W. returned to see Respondent.

   (a) Respondent prescribed Prozac 20 mg 30 tablets, to patient S.W. because Effexor was no longer covered by insurance. Respondent renewed prescriptions for Oxycodone 30 mg 120 tablets, and Klonopin (clonazepam) 1.0 mg 90 tablets. Respondent did not order a urinalysis test on patient S.W. or assess her for diversion.

   (b) Respondent did not document a urinalysis test or assessment for diversion in patient S.W.'s medical records.

33. On or about October 23, 2013, patient S.W. returned to see Respondent.

   (a) Respondent prescribed Prozac 20 mg 30 tablets, Klonopin (clonazepam) 1.0 mg 90 tablets, and increased the Oxycodone 30 mg to 150 tablets. Respondent did not order a urinalysis test on patient S.W. or assess her for diversion.

   (b) Respondent did not document a urinalysis test or assessment for diversion in patient S.W.'s medical records.

34. On or about November 20, 2013, patient S.W. returned to see Respondent.

   (a) Patient S.W. complained of "really bad" knee pain, which Respondent documented as early arthritic changes. Respondent performed no physical examination on patient S.W.'s knees, did not refer her for imaging, and did not refer her to a subspecialist for her complaints of pain. Respondent documented he renewed prescriptions for Oxycodone 30 mg 90 tablets, however Respondent wrote patient S.W. an additional prescription, for Oxycodone 30 mg 60 tablets. He renewed her prescriptions for clonazepam (Klonopin) 1.0 mg 90 tablets, and Prozac 20 mg 30 tablets. Respondent did not order a urinalysis test on patient S.W. or assess her for diversion.

10 Oxycodone 30 mg was prescribed in two prescriptions: one for 90 tablets documented to be paid by insurance, and one for 60 tablets documented to be paid by cash.

11 Prozac (fluoxetine) is a selective serotonin reuptake inhibitor.
(b) Respondent did not document a physical examination of patient S.W.'s knee, document referrals to imaging or to a specialist, did not document an order for urinalysis, assessment for diversion, or document his prescription of an additional 60 Oxycodone tablets in patient S.W.'s medical records.

35. On or about January 15, 2014, patient S.W. returned to see Respondent.

(a) Patient S.W. complained of continuous pain at a level six, and was “doing better.”

Respondent noted that patient S.W. looked well, noted her as stable, but with increased anxiety. Respondent discontinued Prozac and substituted Effexor XR 37.5 mg 30 tablets renewed the other prescriptions, but did not refer patient S.W. to a psychiatrist for further work up, or to a subspecialist for her complaints of pain. Respondent did not order a urinalysis test or assess patient S.W. for diversion.

(b) Respondent wrote patient S.W. an additional prescription for Oxycodone 30 mg 60 tablets, which he did not document in her medical records. Respondent did not document the reason he discontinued Prozac and replaced it with Effexor, did not document a referral for a psychiatric work up, a referral to a subspecialist for pain, an order for a urinalysis test, or assessment for diversion in patient S.W.'s medical records.

36. On or about February 12, 2014, patient S.W. returned to see Respondent.

(a) Respondent noted that he would discontinue Effexor because patient S.W. was experiencing nausea, and prescribe Valium\textsuperscript{12} 5 mg 30 tablets. He prescribed Clonapin (\textit{sic}) [Klonopin] and Oxycodone.

(b) Respondent noted that he advised patient S.W. to take Oxycontin and Valium one to two hours apart, without documenting that he explained the reason for doing so.\textsuperscript{13}

37. On or about February 26, 2014, Respondent ran his first CURES to determine patient S.W.'s compliance with refilling of medications.

\textsuperscript{12} Valium (diazepam) (a benzodiazepine) 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.

\textsuperscript{13} Valium and Klonopin (Clonazepam) are both benzodiazepine medications, and taken together with oxycodone can produce respiratory failure.
38. On or about March 13, 2014, patient S. W. returned to see Respondent.
   
   (a) Patient S. W. complained of pain from her ankles up to her low back. Respondent
   did not perform an examination of patient S. W.’s feet, legs and low back, and advised her
   that she had “early arthritis,” that her knees were locked, “a possible side effect.”
   Respondent prescribed Oxycodone 30 mg 120 tablets, Klonopin 1.0 mg 90 tablets, and
   Valium 5 mg 30 tablets. Respondent failed to discuss the physical side effects and risks of
   combining the two benzodiazepines with an opioid drug with patient S. W. Respondent did
   not obtain and/or refer patient S. W. to a subspecialist for her complaints of pain.
   Respondent did not order a urinalysis or assess her for diversion.
   
   (b) No adequate physical examination, urinalysis test or assessment for diversion was
   recorded in patient S. W.’s medical records.

39. On or about April 10, 2014, patient S. W. returned to see Respondent.
   
   (a) Patient S. W. complained of pain in both ankles, knees and in her upper right arm,
   shoulder, and lower back. She reported that she had fallen. Respondent noted no fracture,
   no dislocation and no limitation of motion, but did not order imaging or order a referral for
   continuing pain. Respondent increased patient S. W.’s prescription of Oxycodone 30 mg to
   150 tablets, and Valium 5 mg 30 tablets, and Klonopin 1.0 mg 90 tablets, were co­
   prescribed. Respondent did not order a urinalysis or assess her for diversion.
   
   (b) No urinalysis test or assessment for diversion was recorded in patient S. W.’s
   medical records.

40. On or about May 8, 2014, patient S. W. returned to see Respondent.
   
   (a) Patient S. W. reported feeling worse during long durations of sitting. Respondent
   did not perform a physical examination on patient S. W., and renewed her prescriptions.
   
   (b) Respondent did not document a physical examination of patient S. W. in her
   medical records.

41. On or about June 5, 2014, patient S. W. returned to see Respondent and he renewed
prescriptions of Oxycodone 30 mg 150 tablets, and Valium 5 mg 30 tablets and Klonopin 1.0 mg
90 tablets.
42. On or about June 27, 2014, patient S.W. returned to see Respondent.
   (a) Patient S.W. reported to the medical assistant that she continued to experience
       pain "everywhere." Respondent did not make a written acknowledgment of patient S.W.'s
       complaint, or perform a physical examination. Respondent failed to obtain and/or refer
       patient S.W. to a subspecialist for her complaints of pain. Respondent did not order a
       urinalysis test on patient S.W. or assess her for diversion. Respondent renewed
       prescriptions for Oxycodeone 30 mg 60 tablets, and Valium 5 mg 15 tablets and Klonopin
       1.0 mg 36 tablets.
       (b) No urinalysis test or assessment for diversion was recorded in patient S.W.'s
           medical records.
43. On or about July 14, 2014, patient S.W. returned to see Respondent.
   (a) Patient S.W. reported she continued to experience pain "everywhere."
   Respondent renewed her prescriptions for Oxycodeone 30 mg 150 tablets, Valium 5 mg 30
   tablets, and Klonopin 1 mg 90 tablets. Respondent did not advise patient S.W. that Valium
   and Klonopin (Clonazepam) are both benzodiazepine medications, and taken together with
   Oxycodeone can produce respiratory failure and did not obtain and/or refer her to a
   subspecialist. Respondent did not clinically integrate patient S.W.'s complaints with a plan
   to renew her prescriptions. Respondent did not order a urinalysis test on patient S.W. or
   assess her for diversion.
   (b) Respondent documented no discussion of medication combinations, referral,
       urinalysis test or assessment for diversion in patient S.W.'s medical records.
44. On or about August 12, 2014, September 9, 2014, and October 7, 2014, Respondent
   returned to see Respondent, complaining of increasing pain at each visit.
   (a) Respondent renewed her prescriptions for Oxycodeone 30 mg 150 tablets, Valium
   5 mg 30 tablets, and Klonopin 1 mg 90 tablets.
   (b) Respondent did not document a referral to any specialist in patient S.W.'s
   medical records.
45. On or about November 4, 2014, patient S.W. returned to see Respondent.

   (a) Patient S.W. complained of pain in her knees, hips and all of her back, and stated
she did not sleep well due to personal problems. She did not want to discuss her anxiety.
Respondent did not refer patient S.W. to a psychiatrist, or a subspecialist for her complaints
of pain, and no further work up of patient S.W.'s pain was ordered. Respondent did not
order a urinalysis test on patient S.W. or assess her for diversion.

   (b) Respondent did not document a urinalysis test, or assessment for diversion in
patient S.W.'s medical records.

Patient A.H.

46. On or about April 29, 2013, patient A.H., a male, first presented to Respondent.

   (a) A prior medical record showed a history of chronic myelocytic leukemia\textsuperscript{14} from
September 3, 2012, and that patient A.H. was under the care of an oncologist. Patient
A.H.'s medical records did not reflect whether his pain resulted from his leukemia. Patient
A.H. had episodes of bilateral kidney stones, and took Oxycodone for pain until he lost
insurance coverage. Respondent prescribed a 15 day prescription of Oxycodone 30 mg 120
tablets, Percocet\textsuperscript{15} 7.5/325 120 tablets, and Xanax 2 mg 30 tablets. Patient A.H.'s MED
dosage exceeded 200 mg, but Respondent had no discussion regarding the risks, benefits,
and alternatives to an opiate regimen with benzodiazepines and did not obtain the patient's
informed consent. Respondent did not order a urinalysis on patient A.H., did not run a
CURES report, and did not evaluate patient A.H. for diversion or addiction. Respondent
and patient A.H. did not enter into a pain management agreement.

   (b) Respondent did not document a discussion regarding the risks, benefits, and
alternatives to an opiate regimen or document an order for a urinalysis test or assessment
for diversion in patient A.H.'s medical records.

\textsuperscript{14} Chronic myelocytic myelogenous leukemia is a type of cancer that starts in certain
blood-forming cells of the bone marrow.

\textsuperscript{15} Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled
substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous
drug pursuant to Business and Professions Code section 4022.
47. On or about May 5, 2013, patient A.H. procured a prescription from another medical provider for Percocet 10/325.


(a) From on or about May 13, 2013, through August 21, 2013, Respondent did not perform adequate history and physicals, or adequately assess patient A.H. for effectiveness of treatment. He did not refer patient A.H. to a subspecialist, order a urinalysis, run a CURES report, or adequately evaluate patient A.H. for diversion or addiction.

(b) No urinalysis test, CURES report, assessment for diversion or referral to a subspecialist was recorded in Patient A.H.'s medical records.

49. On or about September 9, 2013, Respondent became aware that on September 7, 2013, patient A.H. was seen in the Sharp Grossmont Hospital's Emergency Room, where he was assessed as having amnesia and displaying drug seeking behavior. Respondent noted that patient A.H. left the hospital without medical authorization, that Ambien caused sleepwalking, and that patient A.H. cannot be prescribed more medications until September 19, 2013. Respondent further documented that patient A.H. was “upset!” but failed to address behavioral warning signs for possible diversion and/or addiction.

(a) On or about September 10, 2013, nine days before Respondent’s previously imposed refill deadline, patient A.H. returned to see Respondent. Respondent wrote patient A.H. prescriptions for 100 mg 120 tablets of Tramadol, and 350 mg 120 tablets of Soma. Respondent did not order a urinalysis, run a CURES report, or evaluate patient A.H. for diversion and/or addiction. No discussion about patient A.H.'s drug seeking behavior was recorded in the medical record, and no urinalysis test, CURES report, assessment for diversion or referral to a subspecialist was recorded in the medical records.

16 Tramadol is a narcotic-like pain reliever. It is used to treat moderate to severe pain. In 2013, it was not a controlled substance. It was placed into Schedule IV of the Controlled Substances Act (CSA) effective August 18, 2014.
(b) On or about September 18, 2013, one day before Respondent's previously imposed refill deadline, patient A.H. returned to see Respondent. Respondent increased patient A.H.'s dosage of Oxycodone, 60 mg six times per day (480 MED equivalents), and added prescription for Tizanidine.\(^{17}\) Respondent failed to adequately address the reason for the increase in the dosage of Oxycodone, and stated that Tizanidine was given as a replacement of Soma. Respondent did not order a urinalysis, run a CURES report, or adequately evaluate patient A.H. for diversion and/or addiction. No discussion about patient A.H.'s drug seeking behavior, no urinalysis test, CURES report, assessment for diversion or referral to a subspecialist was recorded in the medical records.

50. On or about October 15, 2013, patient A.H. returned to see Respondent. Notes written by a medical assistant stated: "try 20/30 mg methadone in pain now is number eight doesn't last enough!" Respondent wrote, "Oxycodone change to five times per day every two weeks, 300 total amount decreased 60 pills a month try Oxycontin and see if his insurance will cover it." Respondent failed to address behavioral warning signs for possible diversion and/or addiction with patient A.H. and continued to prescribe significant amounts of Oxycodone for patient A.H.

51. On or about December 8, 2013, patient A.H. returned to see Respondent.

(a) Patient A.H. requested a replacement prescription from Respondent reporting that his medications had accidently been "washed" by his fiance.\(^{18}\) Respondent failed to address behavioral warning signs for possible diversion and/or addiction with patient A.H. and continued to prescribe significant amounts of Oxycodone for patient A.H.

(b) Respondent did not document addressing addiction or diversion of medication in patient A.H.'s record.

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\(^{17}\) Tizanidine is a short-acting muscle relaxer.

\(^{18}\) Patient A.H. provided a notarized letter regarding the washing of the medicine.
52. On or about December 16, 2013, patient A.H. returned to see Respondent. Respondent noted that patient A.H.’s insurance company denied the prescriptions for Oxycontin, and Respondent wrote two prescriptions for Oxycodone, for 150 tablets, continuing to prescribe significant amounts of Oxycodone for patient A.H.

**Patient J.V.**

53. On or about January 10, 2013, patient J.V., a male, first presented to Respondent.

(a) The patient intake form reports that patient J.V. had previously been involved in a motor vehicle accident and took Oxycodone 10 mg 4 to 5 times per day. The form included a letter dated August 30, 2013, that referred to a motor vehicle accident, an illegible photo copy of a pill bottle, and photograph of a damaged motor vehicle. Respondent prescribed Oxycodone HCL 30 mg 150 tablets.

(b) Respondent did not document his prescription of Oxycodone in patient J.V.’s medical records.¹⁹

54. On or about February 6, 2013, patient J.V. returned to see Respondent.

(a) Respondent noted that patient J.V.’s regimen with Percocet had been “very successful.” Respondent did not make a formal diagnosis of patient J.V.’s medical issues. An unsigned and undated pain management agreement showed patient J.V. was taking Oxycodone, Norco, and Baclofen,²⁰ and it advised physical therapy. Respondent prescribed Percocet 10/325 150 tablets. Respondent did not assess the risks and/or benefits of treatment with the prescribed medicines with patient J.V., or obtain informed consent regarding the risks and/or benefits of the drug regimen.

(b) Respondent did not document a formal diagnosis of patient J.V.’s medical issues in his medical records.

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²⁰ Baclofen is a muscle relaxer and an antispastic agent.
55. On or about February 13, 2013, patient J.V. returned to see Respondent.

(a) Patient J.V. complained of severe gastrointestinal upset from Percocet. Respondent did not make a formal diagnosis of patient J.V.'s medical issues. However, Percocet was discontinued and APAP Oxycodone 30 mg 150 tablets was prescribed. The prescription of Oxycodone represented a 300% increase in daily dosing.

(b) Respondent did not document patient J.V.'s medical records with an adequate rationale for the 300% increase in daily dosing, and did not document a formal diagnosis of patient J.V.'s medical issues in the medical records.

56. On or about March 4, 2013, patient J.V. returned to see Respondent.

(a) Patient J.V. reported a whiplash injury with neck pain, but he was doing well with the increased dose of Oxycodone. Respondent did not make a formal diagnosis of patient J.V.'s medical issues. Respondent refilled patient J.V.'s prescriptions.

(b) Respondent did not document a formal diagnosis of patient J.V.'s medical issues in his medical records.

57. On or about April 5, 2013, patient J.V. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient J.V., or make a formal diagnosis of his medical issues. Respondent prescribed Oxycodone 30 mg 150 tablets, and Norco 10/325 120 tablets, which represented a 400% MED increase in dosage in the last three months, to 250 MED mg per day, without justification.

(b) Respondent did not document a rationale or justification for the increased dosage in patient J.V.'s medical records and no physical examination, or formal diagnosis of medical issues was recorded in patient J.V.'s medical records.

58. On or about May 8, 2013, patient J.V. returned to see Respondent.

(a) An MRI of the cervical spine had been performed, demonstrating minimal degenerative changes, straightening of the normal lordosis, without nerve root impingement, or spinal cord deformity. No physical examination was performed. Respondent made no formal diagnosis of patient J.V.'s medical issues. Respondent did not advise patient J.V. to use heat and ice, or non-steroidal anti-inflammatory medications for
his injury, and did not refer him to physical therapy, interventional pain management, or to psychological counseling. Respondent prescribed Oxycodone 30 mg 120 tablets, Norco 10.325 120 tablets, and added a prescription for Baclofen 10 mg 90 tablets.

(b) Respondent did not document a physical examination, a formal diagnosis, advice to use heat and ice, or non-steroidal anti-inflammatory medications, or a referral to any specialist in patient J.V.'s medical records.

59. On or about June 26, 2013, patient J.V. returned to see Respondent.

(a) No physical examination was performed. Respondent noted a “urine test for opioids.” Respondent did not make a formal diagnosis of patient J.V.'s medical issues. He refilled patient J.V.'s prescriptions for Oxycodone and Norco.

(b) No test results and no formal diagnosis of medical issues were recorded in patient J.V.’s medical records.

60. On or about July 23, 2013, patient J.V. returned to see Respondent.

(a) Patient J.V. reported that he lost the urinalysis referral slip, so no urinalysis test had been obtained. Respondent failed to assess whether there was any clinical relevance to the patient’s reluctance to provide a urinalysis sample. No physical examination of patient J.V.’s spine was performed. Respondent neither made, nor recorded, a formal diagnosis of patient J.V.’s medical issues. Respondent refilled patient J.V.’s prescriptions.

(b) Respondent did not document a physical examination or formal diagnosis in patient J.V.’s medical records.

61. On or about September 16, 2013, patient J.V. returned to see Respondent.

(a) No physical examination of patient J.V. was performed, and Respondent noted that “physical therapy with yoga” was painful, and patient J.V. had a “hard time to unwind” and “needed to relax.” Respondent did not make a formal diagnosis of patient J.V.’s medical issues. Respondent prescribed Oxycodone 30 mg 150 tablets, Soma 350 mg 30 tablets, and Norco 10/325 90 tablets.

(b) Respondent did not document a physical examination or formal diagnosis in patient J.V.’s medical records.

(a) Medical records dated on or December 20, 2013, reflected neck and back pain at a level seven. A physical examination was performed. Respondent neither made, nor recorded, a formal diagnosis of patient J.V.'s medical issues. A test result showed positive for opioids. Respondent failed to clinically assess whether there was any relevance to patient J.V.'s positive urinalysis test. Respondent prescribed Oxycodone 30 mg 150 tablets, Soma 350 mg 30 tablets, and Norco 10/325 60 tablets.

(b) Respondent documented a positive test result for opioids, however no formal laboratory reports appeared in patent JV's medical records. Respondent did not document the existence of a waiver for in-office urine testing.

63. On or about January 17, 2014, patient J.V. returned to see Respondent.

(a) No physical examination of patient J.V. was performed. Patient J.V.'s neck pain was at a level eight, and he “refused reduction to Oxy 20 mg.” Respondent did not make a formal diagnosis of patient J.V.'s medical issues. Respondent prescribed Oxycodone 30 mg, but reduced the number of tablets to 120 tablets. He did not discuss the risks and/or benefits of the prescribed drug regimen, and did not obtain informed consent for the drug regimen. Respondent also noted that patient J.V. was given a list of pain management addiction specialists to consult.

(b) Patient J.V.’s medical records do not document a physical examination, a formal diagnosis, a discussion of risks and/or benefits of the prescribed drug regimen, and informed consent regarding risks and/or benefits, the reasons why the addiction specialist list was provided to the patient, or a follow up on the question of patient J.V.'s possible diversion or addiction.

\[^{21}\text{On November 13, 2013, Respondent prepared a medical record for patient J.V., but on a later page, noted that he had failed to appear for his appointment and would be charged a failed appointment fee.}\]
64. On or about February 20, 2014, and April 11, 2014, patient J.V. returned to see Respondent and prescriptions were refilled.

65. On or about June 6, 2014, patient J.V. returned to see Respondent.
   (a) Patient J.V. reported chronic pain from his neck to his low back, and inability to sleep. Respondent did not make a formal diagnosis of patient J.V.'s medical issues. Respondent prescribed Oxycodone, Soma and Norco.
   (b) Respondent recorded no formal diagnosis, no information concerning the pain management addiction specialists, or why the list was originally provided to patient J.V. Respondent did not document a follow up on the question of patient J.V.'s possible addiction.


**Patient M.R.**

   (a) Patient M.R. presented with a history of right wrist pain related to a 2007 fracture, resulting in an open reduction internal fixation, a small fracture line, mild scoliosis, proximal pole of the scaphoid and a small cystic change in his right wrist. Surgery occurred in 2008. Patient M.R. reported that he had been recently diagnosed with Hepatitis C, he was taking Lortab 10 mg 150 tablets per month, and used marijuana. Respondent did not have a discussion with patient M.R. regarding his marijuana use.
   Respondent prescribed Oxycodone 10 mg 30 tablets, as needed, and Oxycontin 10 mg 60 tablets. Respondent did not perform a comprehensive initial history and physical examination on patient M.R., or enter into a pain management agreement with him.23

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22 A scaphoid fracture is a break in one of the small bones of the wrist. This type of fracture occurs most often after a fall onto an outstretched hand.

23 On May 20, 2013, a pain management agreement was entered.
Respondent did not order a baseline urinalysis, and did not discuss the risks and/or benefits of the use of opioid prescription drugs with patient M.R.

(b) Respondent did not document performance of a comprehensive initial history and physical examination; discussion of patient M.R.'s possession or non-possession of a medical marijuana recommendation; pain management agreement terms; an order of a baseline urinalysis; or a discussion of the risks and/or benefits of the use of opioid prescription drugs in patient M.R.'s medical records.

68. On or about October 8, 2012, patient M.R. returned to see Respondent. Patient M.R.'s health insurance declined his prescription of Oxycontin. Respondent prescribed MS Contin\(^{24}\) ER 30 mg 60 tablets, with one refill, and Oxycodone 20 mg immediate relief, 60 tablets.

69. On or about November 5, 2012, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R.'s right wrist. Respondent recorded that patient M.R. was doing "very well after adjustment."

(b) Respondent did not document a physical examination of patient M.R.'s right wrist in his medical records.

70. On or about December 3, 2012, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R. and prescribed MS Contin 30 mg 60 tablets, and increased his dosage of Oxycodone from 20 mg 60 tablets to 90 tablets, because patient M.R. reported waking up with pain.

Respondent did not discuss the possibility that patient M.R. was developing hyperalgesia.\(^{25}\)

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\(^{24}\) MS Contin (morphine) is an opioid pain medication.

\(^{25}\) Opioid-induced hyperalgesia is a state of nociceptive sensitization caused by exposure to opioids. The condition is characterized by a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli.
(b) Respondent did not document any physical examination of patient M.R. in his medical records, or document patient M.R.'s medical records for a discussion of the possibility of developing hyperalgesia.

71. On or about December 31, 2012, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R., but noted that a form was signed to document a pre-existing condition in patient M.R., and "certified" that patient M.R. had chronic hepatitis C. viral infection, and chronic pain. Respondent prescribed MS Contin 30 mg 60 tablets and Oxycodone from 20 mg 90 tablets.

(b) Respondent did not document test results verifying hepatitis C, or document a physical examination of patient M.R. in his medical records.

72. On or about January 28, 2013, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination, assess patient M.R. for diversion, for side effects, for effectiveness, order a urinalysis, or run a CURES report. Respondent noted that the present regimen appeared satisfactory, that medications would be refilled, and increased patient M.R.'s prescription for Oxycodone from 20 mg to 30 mg 90 tablets, and refilled his prescription for MS Oxycontin 30 mg 60 tablets.

(b) Respondent did not document a physical examination, assessment for diversion, side effects, or effectiveness, order a urinalysis, a CURES report, or document the reason for his increased prescription of Oxycodone in patient M.R.'s medical records.

73. On or about February 25, 2013, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination on patient M.R.'s right wrist, and refilled patient M.R.'s previous prescriptions.

(b) Respondent did not document a physical examination of patient M.R.'s right wrist in his medical records.

74. On or about March 25, 2013, patient M.R. returned to see Respondent. He did not perform a physical examination on patient M.R.'s right wrist, and refilled patient M.R.'s prescriptions.
75. On or about April 9, 2013, Respondent received a positive urinalysis report regarding patient M.R., showing positive results for marijuana and opiates.

   (a) Respondent did not order further qualitative testing of patient M.R.

   (b) Respondent did not document an order for further testing in patient M.R.’s medical records.

76. On or about April 22, 2013, patient M.R. returned to see Respondent. Respondent refilled patient M.R.’s previous prescriptions.

77. On or about May 20, 2013, patient M.R. returned to see Respondent.

   (a) Respondent increased patient M.R.’s prescription of Oxycontin 10 mg to Oxycontin 30 mg and added Ambien 3.5 mg 30 tablets. Respondent did not discuss the possible interactions of these prescribed substances, or the potentially dangerous combination of benzodiazepines and opioids, or sustained release opioids with patient M.R. Patient M.R. signed a pain management agreement.

   (b) Respondent did not document a discussion of the interactions of these prescribed substances, or a discussion of the prior urinalysis test result.

78. On or about June 17, 2013, patient M.R. returned to see Respondent.

   (a) Respondent did not assess patient M.R. for diversion, side effects, or effectiveness, did not order another urinalysis, or run a CURES report. Respondent did not discuss the possible interactions of the prescribed substances, or discuss his prior positive urinalysis test with patient M.R. Respondent changed patient M.R.’s prescription to prescribe Klonopin 1 mg 30 tablets, and discontinued Ambien. He renewed prescriptions of MS Contin 30 mg 60 tablets, and Oxycodone 30 mg 90 tablets.

   (b) Respondent did not document an assessment of patient M.R. for diversion, side effects, or effectiveness, or document orders for another urinalysis test, or CURES report. Respondent did not document a discussion of prescribed drug interactions or the positive urinalysis test result with patient M.R.
79. On or about July 16, 2013, patient M.R. returned to see Respondent.

   (a) Respondent did not perform a physical examination of patient M.R.'s right wrist.

   Respondent reinstated patient M.R.'s prescription for Ambien, increasing the dosage to 5
   mg 30 tablets, and renewed his prescriptions for MS Contin 30 mg 60 tablets, and
   Oxycodone 30 mg 90 tablets.

   (b) Respondent did not document a physical examination of patient M.R.'s right
wrist, or the reason for the change in patient M.R.'s medications in his medical records.

80. On or about August 13, 2013, patient M.R. returned to see Respondent.

   (a) Respondent did not perform a physical examination of patient M.R.'s right wrist,
but wrote that he would taper down patient M.R.'s “Oxy 30” to “Oxy 20” with “no change
in number,” and prescribed MS Contin 30 mg 60 tablets, and Oxycodone 20 mg 90 tablets.

   (b) Respondent did not document a physical examination of patient M.R.'s right
wrist or the reason for the change in patient M.R.'s medications in his medical records.

81. On or about September 10, 2013, patient M.R. returned to see Respondent.

   (a) Respondent did not perform a physical examination of patient M.R.'s right wrist,
but billed patient M.R.'s insurance company for “Office Visit High 40 min.” Respondent
prescribed MS Contin 30 mg 60 tablets, Oxycodone 20 mg 90 tablets, as recorded in his
notes. However, two prescriptions written on that date show:

   (1) Oxycodone 15 mg 90 tablets, MS Contin 30 mg 60 tablets, Atenolol 25 mg
   30 tablets on prescription number 2268, and

   (2) Oxycodone 20 mg 90 tablets, MS Contin 30 mg 60 tablets, on prescription
number 2624.

   (b) Respondent did not document a physical examination of patient M.R.'s right
wrist, the reason for the change in patient M.R.'s medications, or why the medications
prescribed in prescription numbers 2268 and 2624 were not reflected in patient M.R.'s
medical records.
82. On or about October 8, 2013, patient M.R. returned to see Respondent.

(a) Respondent performed no physical examination on patient M.R.'s right wrist, but noted that patient M.R. had a "wrist #3 with medication." Respondent prescribed Oxycodone 15 mg 90 tablets, and MS Contin 30 mg 60 tablets, and Atenolol 25 mg 30 tablets. Respondent billed patient M.R.'s insurance company for "Office Visit High 40 min" and for an "annual depression screening."

(b) Respondent did not document a physical examination of patient M.R.'s right wrist, a depression screening, or results from a depression screening in patient M.R.'s medical records.

83. On or about November 5, 2013, patient M.R. returned to see Respondent.

(a) Respondent performed no physical examination on patient M.R.'s right wrist, but noted that patient M.R. had a "wrist #2 with medication." Respondent prescribed Oxycodone 15 mg 90 tablets, and MS Contin 30 mg 60 tablets, and Atenolol 25 mg 30 tablets and added Klonopin 1.0 mg 30 tablets. Respondent billed patient M.R.'s insurance company for "Office Visit High 40 min."

(b) Respondent did not document a physical examination of patient M.R.'s right wrist, or the reason for the change in patient M.R.'s medications in his medical records.

84. On or about December 3, 2013, patient M.R. returned to see Respondent.

(a) Respondent discontinued patient M.R.'s prescription of Klonopin, and prescribed Lorazepam 1 mg 30 tablets, MS Contin 30 mg 60 tablets, Atenolol 25 mg 30 tablets, and increased Oxycodone to 20 mg 90 tablets. Respondent did not discuss the interactions of Lorazepam with other medications, including slow released opiates, with patient M.R.

(b) Respondent did not document a discussion of the interactions of Lorazepam with other medications, the reasons for adding Lorazepam or increasing the Oxycodone in patient M.R.'s medical records.

26 Lorazepam (Ativan) belongs to a group of drugs called benzodiazepines.
85. On or about March 18, 2014, patient M.R. returned to see Respondent. Respondent changed patient M.R.’s medication regimen to Oxycontin 30 mg 60 tablets, added morphine sulfate\(^{27}\) 30 mg 90 tablets, continued Atenolol, 25 mg 60 tablets.

86. On or about April 17, 2014, patient M.R. returned to see Respondent. Respondent changed patient M.R.’s medication regimen to Oxycontin 30 mg 90 tablets, and refilled the prescriptions of morphine sulfate 30 mg 90 tablets, and Atenolol, 25 mg 60 tablets.

87. On or about May 15, 2014, patient M.R. returned to see Respondent.

(a) Patient M.R. was referred to occupational therapy and was told that nothing would be done for him while he awaited referral to orthopedics. Respondent did not perform a physical examination of patient M.R.’s right wrist, refer him to an interventional pain management specialist, run a CURES report, order urinalysis for patient M.R. or discuss the prior positive urinalysis for marijuana. A CVS Pharmacy refill form noted that Respondent authorized three prescription refills for Atenolol 25 mg 60 tablets, beginning July 8, 2014.

(b) Respondent did not document a physical examination of patient M.R.’s right wrist, or document the reason for his authorization of three prescription refills for Atenolol 25 mg 60 tablets, beginning July 8, 2014, in patient M.R.’s medical records.

88. On or about June 17, 2014, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R.’s right wrist, but discontinued morphine sulfate ER and added Dilaudid 4 mg 90 tablets.

(b) Respondent did not document a physical examination of patient M.R.’s right wrist, or the reason for the change of medications in patient M.R.’s medical records.

89. On or about July 10, 2014, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R.’s right wrist, but changed patient M.R.’s prescription from morphine sulfate 30 mg extended release, to

\(^{27}\) Morphine Sulfate is an opioid agonist. Opioid agonists bind to the opioid receptors and provide pain relief. Morphine is a pure opioid agonist whose principal therapeutic action is analgesia. Other members of the class known as opioid agonists include substances such as oxycodone, hydromorphone, fentanyl, codeine, and hydrocodone.
morphine sulfate 60 mg and added hydromorphone (Dilaudid) 28 4 mg 90 tablets.

Respondent wrote a new prescription for Atenolol, 25 mg 60 tablets, although he had, on May 15, 2014, renewed patient M.R.'s Atenolol prescription beginning July 7, 2014, for three refills.

(b) Respondent did not document a physical examination of patient M.R.'s right wrist or the reason for a change in prescribed medications. Respondent did not document the reason he renewed Atenolol 25 mg 60 tablets beginning on July 7, 2014, and wrote a new prescription for the same medication on July 10, 2014.

89. On or about August 7, 2014, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R.'s right wrist, and wrote prescriptions for Atenolol 25 mg 60 tablets, morphine sulfate, 60 mg 90 tablets, and Dilaudid 4 mg 90 tablets.

(b) Respondent did not document patient M.R.'s medical records with the reason he wrote a new prescription of Atenolol, 25 mg 60 tablets, in addition to the three prescription renewals of Atenolol authorized on May 15, 2014.

90. On or about September 4, 2014, patient M.R. returned to see Respondent.

(a) Respondent did not perform a physical examination of patient M.R.'s right wrist, but noted that patient M.R. had accidently cut his left hand and had stitches placed at an emergency room. Respondent increased patient M.R.'s Dilaudid to 8 mg 90 tablets and renewed prescriptions for Atenolol 25 mg 60 tablets, and morphine sulfate, 60 mg 90 tablets. Respondent did not discuss the combination of benzodiazepines and sustained release opioids, or the combination of other medications with patient M.R.

(b) Respondent did not document a physical examination, or the reason he wrote another prescription of Atenolol, 25 mg 60 tablets, in addition to the prescription renewals of Atenolol authorized on May 15, 2014, or why he increased the dosage of Dilaudid in patient M.R.'s medical records.

28 Hydromorphone (Dilaudid) is an opioid and a Schedule II controlled substance.

92. On or about November 27, 2014, Respondent wrote patient M.R. two prescriptions for each of the following: Atenolol 25 mg 60 tablets, and morphine sulfate 30 mg 45 tablets.

93. On or about November 28, 2014, patient M.R. returned to see Respondent.

Respondent did not perform a physical examination of patient M.R.'s right wrist.

94. On or about December 12, 2014, patient M.R. returned to see Respondent.

(a) Respondent did not conduct a physical examination on patient M.R.'s right wrist. Respondent noted that an orthopedic consultation occurred, and wrote "can't do anything for now." Respondent noted an intention to taper down patient M.R.'s pain medication and reduce morphine sulfate to every 12 hours and hydromorphone (Dilaudid) to four mg in January, and renewed prescriptions for Atenolol 25 mg 60 tablets, morphine sulfate 60 mg 90 tablets, and Dilaudid, 8 mg 90 tablets.

(b) Respondent did not document a physical examination of patient M.R. in his medical records.

**Patient D.Y.**

95. On or about August 14, 2014, patient D.Y., a male, became a patient of Respondent, presenting with mild osteoarthritic changes of the lumbar spine and chronic low back pain, but no significant nerve root impingement, and a transplanted kidney. Respondent did not perform a physical examination of patient D.Y. Patient D.Y. reported that he previously took Norco 10/325, four tablets a day, a 40 MED per day. Patient D.Y. entered into a pain management contract with Respondent on August 14, 2014. Respondent planned to prescribe Oxycodone 20 mg 120 tablets, Oxycontin ER 15 mg 60 tablets, and prescriptions were written on August 21, 2014.

96. On or about September 4, 2014, patient D.Y. returned to see Respondent. Oxycontin was discontinued because insurance would not pay for it, and Respondent prescribed an increased dosage of Oxycodone, Oxycodone 30 mg, 120 tablets.
97. On or about October 2, 2014, patient D.Y. returned to see Respondent.

(a) Patient D.Y.'s medication prescription was renewed. Respondent had no discussion with patient D.Y. regarding diversion or addiction. No urinalysis was performed and no CURES report was run.

(b) Respondent did not document any discussion with patient D.Y. regarding diversion or addiction, or document an order for a urinalysis or CURES report.

98. On or about October 30, 2014, patient D.Y. returned to see Respondent.

(a) Patient D.Y. reported that he would be out of town starting November 11, 2014, and his medicine did not "last long enough." Respondent did not perform an adequate physical examination of patient D.Y. Respondent added morphine sulfate 60 mg 60 tablets to the Oxycodone 30 mg 120 tablets.

(b) Respondent did not document an adequate physical examination of patient D.Y.

99. On or about November 26, 2014, Respondent had a telephone consultation with Patient D.Y., who reported he was out of state. Respondent prescribed Oxycodone 30 mg 120 tablets, and mailed it to the patient on December 2, 2014, to be refilled out of state.

100. On or about December 26, 2014, patient D.Y. returned to see Respondent.

(a) Patient D.Y. complained of low back pain radiating to his left leg. Respondent did not perform an adequate physical examination of patient D.Y. and he prescribed Opana\(^{29}\) ER 20 mg 60 tablets, and Oxycodone 30 mg 90 tablets.

(b) Respondent did not document the reason why he changed patient D.Y.'s medication regimen from morphine sulfate to Opana\(^{30}\) or an adequate physical examination of patient D.Y.

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\(^{29}\) Opana (oxymorphone) is an opioid pain medication and is a Schedule II controlled substance.

\(^{30}\) Opana (oxymorphone hydrochloride) a semi-synthetic opioid analgesic, is a brand name for oxymorphone hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.
101. On or about January 22, 2015, patient D.Y. returned to see Respondent.
   (a) Patient D.Y. reported increasing back pain, and his medication was not effective.
   Respondent did not perform an adequate physical examination on patient D.Y. or examine
   his back. Patient D.Y.'s insurance did not cover Opana but covered Oxycontin.
   Respondent prescribed Oxycontin ER 80 mg 60 tablets, Atenolol 50 mg 30 tablets, and
   Oxycodone 30 mg 120 tablets, which represents a MED of 424 mg, an escalating 1000%
   increase over patient D.Y.'s original prescription level in five months, without
   corresponding improvement to quality of life. Respondent did not discuss diversion or
   addiction with patient D.Y.
   (b) Respondent did not document an adequate physical examination, or any reason
   why he dramatically increased patient D.Y.'s dosage of medicines, and did not document
   any discussion with patient D.Y. regarding diversion or addiction.

102. On or about March 4, 2015, Respondent ran a CURES report on patient D.Y. which
   showed that between August 14, 2014 and January 16, 2015, while under Respondent's care,
   patient D.Y. filled prescriptions for hydrocodone bitartrate/acetaminophen and Carisoprodol
   (Soma) written by another physician. 31

103. On or about March 19, 2015, patient D.Y. returned to see Respondent.
   (a) Patient D.Y. reported continued low back pain, and said the medications were
   effective. Respondent did not perform an adequate physical examination of patient D.Y.
   Patient D.Y. was asked to provide a urine sample for a urinalysis test, but did not do so.
   Respondent allowed the urine sample to be provided "another time," and renewed
   prescriptions for Oxycontin ER 80 mg 60 tablets, Atenolol 50 mg 30 tablets, and
   Oxycodone 30 mg 120 tablets. Respondent did not have a discussion with patient D.Y.
   about the medications that were prescribed by the other physician.

31 Carisoprodol (Soma) a muscle relaxant, has been added as a Schedule IV controlled
   substances since December 12, 2011.
(b) Respondent did not document an adequate physical examination of patient D.Y., a discussion with patient D.Y.'s regarding addiction, or diversion, and did not document a discussion about the medications that were prescribed by the other physician.

104. On or about May 14, 2015, patient D.Y. returned to see Respondent.

(a) Patient D.Y. complained of continued low back pain. Respondent did not perform a physical examination on patient D.Y. He noted he would “try to taper opioids.” Respondent renewed patient D.Y.'s prescriptions for Oxycontin ER 80 mg 60 tablets, Atenolol 50 mg 30 tablets, and Oxycodone 30 mg 120 tablets. Respondent did not make a further attempt to obtain a urine sample.

(b) Respondent did not document further attempts to obtain a urine sample or an adequate physical examination of patient D.Y.

105. On or about May 14, 2015, patient D.Y. returned to see Respondent.

(a) Patient D.Y. complained of continued low back pain. Respondent did not perform an adequate physical examination of patient D.Y. Respondent renewed patient D.Y.'s prescriptions for Oxycontin ER 80 mg 60 tablets, Atenolol 50 mg 30 tablets, and Oxycodone 30 mg 120 tablets. Respondent did not make a further attempt to obtain a urine sample.

(b) Respondent did not document further attempts to obtain a urine sample, or an adequate physical examination of patient D.Y.

106. On or about May 29, 2015, Respondent ran a CURES report on patient D.Y. which showed that between January 16, 2015, and April 26, 2015, while under Respondent’s care, patient D.Y. filled prescriptions for Carisoprodol written by another physician.

107. On or about June 2, 2015, patient D.Y. returned to see Respondent. Patient D.Y. complained of continued low back pain, reporting that his pain level was unchanged. Patient D.Y. was asked to provide a urine sample for a urinalysis test, but reported he was unable to provide a sample. No physical examination was performed on patient D.Y. Respondent renewed patient D.Y.'s prescriptions for Oxycontin ER 80 mg 60 tablets, Atenolol 50 mg 30 tablets, and Oxycodone 30 mg 120 tablets.
108. On or about June 3, 2015, patient D.Y. provided a urine sample for analysis. The
report showed that prescribed medications tested negative in patient D.Y.'s system, but
medications that Respondent had not prescribed tested positive.

**Patient V.B.**


(a) Patient V.B. complained of pain in his neck, low back, and knee, at a level of 8 to
9/10, and presented MRIs of his cervical and lumbar spine, and knee, which demonstrated
mild degenerative changes, and mild disk height reduction in the spine. The knee was not
severely degenerated or deranged. Patient V.B. reported taking Oxycodone, Oxycontin 80
mg 180 tablets (representing 700 MED equivalents per day) for effective pain relief, plus
Opana. He requested an additional prescription of Oxycodone, 30 mg 90 tablets.
Respondent did not take patient V.B.'s vital signs, or perform a physical examination.
Respondent prescribed Oxycontin ER 80 mg 180 tablets, and Oxycodone 30 mg 180
tablets.

(b) Respondent did not document patient V.B.'s vital signs, a physical examination, a
discussion of why patient V.B. concurrently took two extended release opiates, or why he
"does not want to return to" his previous physician.

110. On or about December 31, 2012, patient V.B. returned to see Respondent.

(a) Respondent prescribed Oxycontin 80 mg 180 tablets, Oxycodone 30 mg 180
tablets, and Oxycodone 40 mg 60 tablets.

(b) Respondent did not document the reason for prescribing the medications, or the
reason for adding Oxycodone 40 mg to patient V.B.

111. On or about January 30, 2013, patient V.B. returned to see Respondent.

(a) Patient V.B. reported increased pain. Respondent discussed the possibility of
degenerative joint disease with patient V.B., but did not refer him to a subspecialist.
Respondent did not run a CURES report, or evaluate patient V.B. for diversion. A CURES
report would have shown that patient V.B. was receiving multiple prescriptions for
controlled substances from multiple health care providers. Respondent prescribed
Oxycontin 80 mg 180 tablets, Oxycodone 30 mg 240 tablets, and Oxycodone 40 mg 60 tablets.

(b) Respondent did not document discussion of addiction or diversion, an evaluation for addiction or diversion, referral to a subspecialist, or ordering a CURES report.

112. On or about February 7, 2013, patient V.B. returned to see Respondent. Respondent did not perform a physical examination on patient V.B., and stated that he was doing well under the “presently established program.” Respondent prescribed Oxycontin 80 mg 180 tablets, Oxycodone 30 mg 240 tablets (quadrupling the number of tablets prescribed), and Oxycodone 40 mg 60 tablets, and referred him for hip x-rays.

113. On or about March 27, 2013, patient V.B. returned to see Respondent. No further discussion occurred in regard to the referral for hip x-rays. Respondent renewed his prescriptions.

114. On or about April 24, 2013, patient V.B. returned to see Respondent. No further discussion occurred in regard to the referral for hip x-rays. Respondent discontinued the prescription for Oxycodone 40 mg, but did not document the reason for changing the prescription. Respondent prescribed Oxycontin 80 mg 180 tablets, and increased the number of Oxycodone 30 mg from 240 tablets to 320 tablets.

115. On or about May 22, 2013, patient V.B. returned to see Respondent. No further discussion occurred in regard to the referral for hip x-rays. Respondent documented the increase in need of controlled substances was very concerning, and the patient “clearly fits the designation of being addicted.” He wrote that his office was not qualified to treat and rehabilitate the patient, who was given a list of addiction specialists. Respondent prescribed Oxycodone 30 mg 160 tablets and Oxycontin 80 mg 90 tablets.

116. On or about June 5, 2013, patient V.B. returned to see Respondent. Respondent did not perform a physical examination of patient V.B., and renewed his prescriptions of Oxycodone 30 mg 160 tablets and Oxycontin 80 mg 90 tablets.

117. Respondent was grossly negligent and committed extreme departures from the standard of care in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y. and V.B., which include, but are not limited to the following:
Patient R.W.

118. From on or about November 13, 2013, to on or about April 21, 2014, Respondent failed to adequately prepare, follow and document a plan that included all of the following: an appropriate prior physical examination ("a good faith physical examination"); assessment of the benefits of treatment; informed consent of the patient based on the benefits and risks of treatment; periodic review of treatment; adjustment of patient treatment; and prevention of diversion for Patient R.W.

119. From on or about November 13, 2013, to on or about April 21, 2014, Respondent failed to order and/or obtain appropriate consultation with any subspecialist for patient R.W.

Patient S.W.

120. From on or about January 24, 2013, to on or about November 4, 2014, Respondent failed to adequately prepare, follow and document a plan that included all of the following: an appropriate prior physical examination ("a good faith physical examination"); assessment of the benefits of treatment; informed consent of the patient based on the benefits and risks of treatment; periodic review of treatment; adjustment of patient treatment; and prevention of diversion for patient S.W.

121. From on or about January 24, 2013, to on or about November 4, 2014, Respondent failed to order and/or obtain a consultation with any subspecialist for patient S.W.

Patient A.H.

122. From on or about April 29, 2013, to on or about December 16, 2013, Respondent failed to adequately prepare, follow and document a plan that included all of the following: an appropriate prior physical examination ("a good faith physical examination"); assessment of the benefits of treatment; informed consent of the patient based on the benefits and risks of treatment; periodic review of treatment; adjustment of patient treatment; and prevention of diversion for patient A.H.

Patient J.V.

123. From on or about January 10, 2013, to on or about August 20, 2013, Respondent failed to adequately prepare, follow and document a plan that included all of the following: an
appropriate prior physical examination ("a good faith physical examination"); assessment of the
benefits of treatment; informed consent of the patient based on the benefits and risks of treatment;
periodic review of treatment; adjustment of patient treatment; and prevention of diversion for
patient J.V.

124. From on or about January 10, 2013, to on or about August 20, 2014, Respondent
failed to appropriately follow up and order referrals for the patient when the suspect signs of
addiction were present for patient J.V.

**Patient M.R.**

125. From on or about August 14, 2012, to on or about December 12, 2014, Respondent
failed to adequately prepare, follow and document a plan that included all of the following: an
appropriate prior physical examination ("a good faith physical examination"); assessment of the
benefits of treatment; informed consent of the patient based on the benefits and risks of treatment;
periodic review of treatment; adjustment of patient treatment; and prevention of diversion for
patient M.R.

**Patient D.Y.**

126. From on or about August 14, 2014, to on or about June 3, 2015, Respondent failed to
adequately prepare, follow and document a plan that included all of the following: an appropriate
prior physical examination ("a good faith physical examination"); assessment of the benefits of
treatment; informed consent of the patient based on the benefits and risks of treatment; periodic
review of treatment; adjustment of patient treatment; and prevention of diversion for patient D.Y.

**Patient V.B.**

127. From on or about December 4, 2012, to on or about June 5, 2013, Respondent failed
to adequately prepare, follow and document a plan that included all of the following: an
appropriate prior physical examination ("a good faith physical examination"); assessment of the
benefits of treatment; informed consent of the patient based on the benefits and risks of treatment;
periodic review of treatment; adjustment of patient treatment; and prevention of diversion for
patient V.B.
SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

128. Respondent has subjected his Physician's and Surgeon's Certificate No. C 50765 to
discipline under sections 2227 and 2234, as defined by 2234, subdivision (c) of the Code, as more
particularly alleged in paragraphs 13 through 127, above, in that he committed repeated negligent
acts in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y. and V.B., which are
hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE
(Incompetence)

129. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50765 to
discipline under sections 2227 and 2234, as defined by 2234, subdivision (d) of the Code, as more particularly alleged in paragraphs 13 through 127, above, in that he committed acts of incompetence in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y. and V.B., which are hereby incorporated by reference and realleged as if fully set forth herein:

130. Respondent's acts of incompetence in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y. and V.B., included, but were not limited to the following:

Patient R.W.

131. Respondent failed to clinically assess whether there was any relevance regarding patient R.W.'s positive urinalysis test result.

132. Respondent failed to observe patient R.W.'s medical confidentiality rights when discussing his medical issues with his mother.

Patient S.W.

133. Respondent concurrently prescribed two types of benzodiazepine medications with a high dose of opioid therapy to patient S.W. without ordering and/or obtaining a subspecialist consultation for patient S.W.

Patient A.H.

134. Respondent failed to address the patient A.H.'s behavioral warning signs for possible diversion and/or addiction.
135. Respondent prescribed significant increased daily doses of Oxycodone to patient A.H.
without adequate justification.

**Patient J.V.**
136. Respondent increased patient J.V.'s medications to 400% over baseline MED equivalents without justification.
137. Respondent failed to clinically assess whether there was any relevance regarding
patient J.V.'s positive urinalysis test result.

**Patient M.R.**
138. Respondent failed to have an appropriate discussion with patient M.R. regarding his
positive urinalysis test results for marijuana, at any time during patient M.R.'s treatment.
139. Respondent prescribed a dangerous combination of benzodiazepines and sustained
release opioids to patient M.R. that was not justified by physical findings and the potential danger
of the drug interactions was not discussed with patient M.R.

**Patient D.Y.**
140. In January 2015, Respondent prescribed escalating dosages of medications to patient
D.Y. which ultimately represented an approximate 1000% MED increase, for a non-specific
lumbar disc degeneration.

**Patient V.B.**
141. Respondent prescribed doses of Oxycodone of high MEDs per day to patient V.B. for
mild disk degeneration and mild tricompartmental degeneration of the knee.

**FOURTH CAUSE FOR DISCIPLINE**
(The Commission of any Act Involving Dishonesty or Corruption
Substantially Related to the Qualifications, Functions and Duties of a Physician)

142. Respondent has further subjected his Physician's and Surgeon's Certificate
No. C 50765 to discipline under sections 2227 and 2234, as defined by 2234, subdivision
(e) of the Code, in that he has committed acts of dishonesty and corruption, as more
particularly alleged in paragraphs 13 through 127, above, which are hereby incorporated
by reference and realleged as if fully set forth herein:

ACCUSATION NO. 8002014004551
143. Respondent is a physician who trained and worked as a radiologist until he retired. Thereafter, in or about July of 2011, Respondent returned to the practice of medicine, opening a solo practice in the specialty of pain management. In or about 2013, Respondent closed his solo practice and took employment at an entity known as "House Calls, Inc."

144. On or about April 14, 2014, the Medical Board of California (Board), through its Consumer Complaint Unit, received a consumer complaint asserting that Respondent was excessively prescribing opioids to a patient, and a tape recorded interview was conducted by a Health Quality Investigation Unit investigator, and District Medical Consultant.

Respondent's Contact With the DEA

145. On or about October 14, 2015, Respondent and his attorney attended the first session of Respondent's Medical Board subject interview regarding his practices in prescribing controlled substances. The first portion of that interview was conducted by Health Quality Enforcement (HQIU) Investigator A.M. Investigator A.M. asked Respondent whether the DEA had ever contacted him, and Respondent answered, "no."

146. Respondent had been contacted by the DEA on three occasions:

(a) In and about Spring of 2013, Respondent was prescribing medication to patient S.C. On or about April 23, 2013, S.C. was arrested and incarcerated, and mentioned Respondent in a telephone conversation recorded by the police. Following up on this information, on April 29, 2013, a DEA Special Agent telephoned Respondent to discuss patient S.C.'s upcoming medical appointment.

(b) On or about May 1, 2013, DEA Special Agents met with Respondent at his office to further discuss his prescribing of controlled substances.

32 During his incarceration, patient S.C. was trying to find someone to loan him money to pay bail, and telephoned his mother to request a loan. In a recorded telephone conversation, patient S.C. referred to his upcoming office visit to Respondent as a future source of income, stating that if the money was loaned to him, he could repay that loan on May 1, because on that day he would again go to see Respondent to obtain additional prescriptions.
(c) On or about May 20, 2013, DEA Special Agents met with Respondent, discussed his patients, and advised Respondent to perform complete physical examinations, use the CURES system, use pain management agreements, and obtain patients' medical records, and X-Rays and MRIs before prescribing medications.

**Respondent's Changes to Medical Records**

147. On or about December 3, 2015, Respondent and his attorney attended the second session of Respondent's subject interview. Respondent brought and used original patient records to support his statements regarding the care and treatment he provided to his patients. However, when discussing Patient V.B., Respondent's original records dated April 24, 2012, and December 4, 2012, those medical records were found to contain information that was not on previously produced subpoenaed copies.

148. On or about December 3, 2015, the District Medical Consultant (DMC) found that the subpoenaed records might be incomplete, and reviewed the original records brought by Respondent. The DMC noted that patient V.B.'s July 3, 2012, medical record showed only an examination for blood pressure. Respondent's counsel said that his photocopy of that medical record did not show a note for blood pressure. Patient V.B.'s July 3, 2012, medical records were found to contain information that was not on the previously subpoenaed record.

**Respondent's Charge for Services Not Performed**

149. On or about October 8, 2013, patient M.R. presented for an office visit with Respondent. Respondent performed no physical examination on patient M.R.'s right wrist, but noted that patient M.R. had a "wrist #3 with medication." Respondent prescribed Oxycodone 15 mg 90 tablets, and MS Contin 30 mg 60 tablets, and Atenolol 25 mg 30 tablets. Respondent billed patient M.R.'s insurance company for "Office Visit High 40 min" and for an "annual depression screening." Respondent did not document a physical examination of patient M.R.'s right wrist, or a depression screening, and no records concerning a depression screening were included in patient M.R.'s medical records.
FIFTH CAUSE FOR DISCIPLINE
( Failure to Maintain Accurate and Adequate Medical Records)

150. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50765 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain accurate and adequate medical records in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y., and V.B., as more particularly alleged in paragraphs 13 through 149, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE
(Excess Prescribing)

151. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50765 to disciplinary action under sections 2227 and 725, as defined by section 725 of the Code, in that he prescribed excessively to patients R.W., S.W., A.H., J.V., M.R., D.Y., and V.B., as more particularly alleged in paragraphs 13 through 150, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

152. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50765 to disciplinary action under sections 2227 and 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y., and V.B., as more particularly alleged in paragraphs 13 through 151, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE
(Violation of a Provision or Provisions of the Medical Practice Act)

153. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50765 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
subdivision (a), of the Code, in that he has violated a provision or provisions of the Medical Practice Act, in his care and treatment of patients R.W., S.W., A.H., J.V., M.R., D.Y., and V.B., as more particularly alleged in paragraphs 13 through 152, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

CAUSE OF ACTION UNDER THE BUSINESS AND PROFESSIONS CODE

(Respondent's Ability to Safely Practice his Profession is Impaired Due to a Personality Disorder/Mental Disorder)

154. Respondent has subjected his Physician's and Surgeon's Certificate No. C 50765 to action under sections 820 and 822 of the Code, in that he has a personality disorder/mental disorder that impairs his ability to practice medicine in a safe manner, as more particularly alleged in paragraphs 13 through 153, above, which are hereby incorporated by reference and realleged as if fully set forth herein:

155. On or about January 5, 2016, Respondent signed a voluntary consented to a mental health examination. The examination was conducted by a psychiatrist, Alan Abrams, M.D. Respondent was reported to suffer from a personality disorder/mental disorder that impairs his ability to practice in a safe manner, and to represent an immediate threat to the health and safety of the patients and a danger to the public.

156. On or about March 26, 2016, Dr. Abrams reported that while a personality disorder is not often an impairing mental condition, in Respondent's case, it is. Respondent's unwillingness to consider his practice methods critically is the result of this personality disorder.

157. By 2011, Respondent had taken 14 hours of pain management training. At that time, Respondent established himself as a specialist in pain management with minimal training, which strongly supports a grandiose sense of self-importance.

158. Dr. Abrams further noted Respondent's lack of apparent concern after the DEA warning, opining that "[t]his level of 'willful ignorance' is very dangerous in a medical practice of any sort, but particularly where dangerous controlled substances are prescribed in large quantities." Dr. Abrams further opined that Respondent's personality disorder impairs his ability to see the larger public health issues/dangers of excessive prescribing, and he is quite intelligent.
and clever, and his personality disorder will cause him to continue to practice as he sees in his best interests, and to offer pretext rationalizations, corrections or adjustments in his practice if he feels he can outmaneuver and/or outsmart others.

**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:

2. Revoking, suspending or denying approval of Respondent Wolfram R. Forster, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;
3. Ordering Respondent Wolfram R. Forster, M.D., if placed on probation, to pay the Board the costs of probation monitoring;
4. Taking action as authorized by section 822 of the code, as the Board, in its discretion, deems reasonable and proper, and
5. Taking such other and further action as deemed necessary and proper.

DATED: August 26, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant