

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

In the Matter of the Accusation Against:)
)
DAVID CHRISTOPHER IANACONE, M.D.) Case No. 09-2011-219454
)
Physician's and Surgeon's)
Certificate No. G 75636)
)
Respondent)
_____)

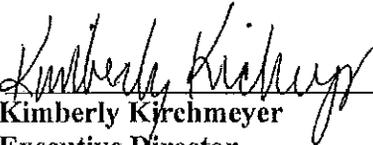
DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on August 31, 2015.

IT IS SO ORDERED August 24, 2015.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 TESSA L. HEUNIS
Deputy Attorney General
4 State Bar No. 241559
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5 San Diego, CA 92101
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8 *Attorneys for Complainant*

9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:

Case No. 09-2011-219454

14 **DAVID CHRISTOPHER IANACONE,**
M.D.,
15 **2335 COMPASS POINTE DR**
VERO BEACH FL 32966-2114

STIPULATED SURRENDER OF
LICENSE AND DISCIPLINARY ORDER

16
17 **Physician's and Surgeon's**
Certificate No. G75636

18 Respondent.

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Kimberly Kirchmeyer (complainant) is the Executive Director of the Medical Board
24 of California, Department of Consumer Affairs (Board). She brought this action solely in her
25 official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the
26 State of California, by Tessa L. Heunis, Deputy Attorney General.

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1 CULPABILITY

2 8. Respondent does not contest that, at an administrative hearing, complainant could
3 establish a *prima facie* case with respect to the charges and allegations contained in Accusation
4 No. 09-2011-219454, a true and correct copy of which is attached hereto as Exhibit "A," and that
5 he has thereby subjected his Physician's and Surgeon's Certificate No. G 75636 to disciplinary
6 action.

7 9. Respondent agrees that his Physician's and Surgeon's Certificate No. G 75636 is
8 subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth
9 in the Disciplinary Order below.

10 10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's
11 and Surgeon's Certificate No. G 75636, or if an accusation is filed against him before the Board,
12 all of the charges and allegations contained in Accusation No. 09-2011-219454 shall be deemed
13 true, correct, and fully admitted by respondent for purposes of any such proceeding or any other
14 licensing proceeding involving respondent in the State of California or elsewhere.

15 CONTINGENCY

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

19 12. Respondent understands that, by signing this stipulation, he enables the Executive
20 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his
21 Physician's and Surgeon's Certificate No. G 75636 without further notice to, or opportunity to be
22 heard by, respondent.

23 13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the
24 approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated
25 Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her
26 consideration in the above-entitled matter and, further, that the Executive Director shall have a
27 reasonable period of time in which to consider and act on this Stipulated Surrender of License and
28 Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands

1 and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the
2 time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

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

21 **ADDITIONAL PROVISIONS**

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

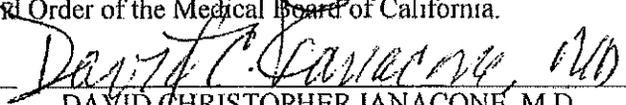
25 16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary
26 Order, including copies of the signatures of the parties, may be used in lieu of original documents
27 and signatures and, further, that such copies shall have the same force and effect as originals.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Paul Spackman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 75636. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/13/2015 
DAVID CHRISTOPHER IANACONE, M.D.
Respondent

I have read and fully discussed with respondent David Christopher Ianacone, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 4/15/2015 
PAUL SPACKMAN, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 4/15/15 Respectfully submitted,
KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General


TESSA L. HEUNIS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 09-2011-219454

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 MICHAEL S. COCHRANE
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7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9 BEFORE THE
10 MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
11 STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:
13 DAVID CHRISTOPHER IANACONE, M.D.
12815 Heacock Street
14 Moreno Valley, CA 92553
15 Physician's and Surgeon's Certificate
16 No. G75636,
17 Respondent.

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 17 20 14
BY R. FIRDPAUS ANALYST

Case No. 09-2011-219454

ACCUSATION

18 Complainant alleges:

19 PARTIES

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

23 2. On or about December 2, 1992, the Medical Board of California issued Physician's
24 and Surgeon's Certificate No. G75636 to David Christopher Ianacone, M.D. (Respondent). The
25 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
26 charges brought herein and will expire on December 31, 2014, unless renewed.

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

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

“(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

“(b) Gross negligence.

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

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

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

“...”

6. Section 2238 of the Code states:

“A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.”

7. Section 2242 of the Code states, in pertinent part:

“(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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“...”

8. Health and Safety Code section 11210 states, in pertinent part, that:

“A physician ... may prescribe for, furnish to, or administer controlled substances to his or her patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.

“The physician ... shall prescribe, furnish, or administer controlled substances only when in good faith he or she believes the disease, ailment, injury, or infirmity requires the treatment.

“The physician ... shall prescribe, furnish, or administer controlled substances only in the quantity and for the length of time as are reasonably necessary.”

9. Health and Safety Code section 11190, states, in pertinent part:

“(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

“(1) The name and address of the patient.

“(2) The date.

“(3) The character, including the name and strength, and quantity of controlled substances involved.

“(b) The prescriber’s record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

“...”

10. Section 2266 of the Code states:

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

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1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence)

3 11. Respondent is subject to disciplinary action under sections 2227 and 2234, as
4 defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in
5 his care and treatment of patients B.P., E.F., R.D., C.B., W.B., S.C., and V.A., as more
6 particularly alleged hereinafter:

7 (a) **Patient B.P.**

8 (1) On or about December 8, 2008, respondent saw patient B.P. for the first time at
9 Kaiser Permanente's Chronic Pain Management Program. Respondent noted that patient B.P.
10 "was recently in the Psych Ward" but was "unable to elucidate why of admission." Patient B.P.
11 was unable to identify any injury to his lumbar spine, but stated that "he was attacked and hit in
12 the 'T' spine with a fireplace poker and he has had pain in that area for some time." Patient B.P.
13 had been previously diagnosed with amphetamine dependence, alcohol abuse, and marijuana
14 abuse, bipolar disorder, and depression. Patient B.P. reported having back pain of 10/10.
15 Respondent told patient B.P. that 10/10 pain level requires total immobility secondary to pain
16 intensity, and patient B.P. responded by accusing respondent of not listening to his pain
17 complaint. No physical examination of patient B.P.'s back was performed or documented. The
18 plan was to refer patient B.P. to physical therapy, referral to anesthesia procedure clinic, obtain an
19 x-ray of the thoracic spine, Naprosyn 500 mg bid, and Norco¹ (Hydrocodone 10 mg /
20 Acetaminophen 325 mg), 1-2 tablets every 6 hours as needed.

21 (2) On or about December 16, 2008, patient B.P. was seen by Dr. H.K., pursuant to a
22 referral by respondent. A musculoskeletal examination revealed normal gait and station, mild
23 tenderness to palpation at the L4 and T10 levels and at the muscles around the spine. Dr. H.K.
24 concluded that the lumbar spine was stable and without pelvic diastasis. There were no palpable

25 _____
26 ¹ "Norco," a brand name for Hydrocodone/Acetaminophen, is a Schedule III controlled substance
27 from the opiates class pursuant to Health and Safety Code section 11056, subdivision (e), and Title 21 of
28 the Code of Federal Regulations, section 1308.13, subdivision (e)(1)(iv), and is a dangerous drug pursuant
to Business and Professions Code section 4022.

1 trigger points in the low back muscles, and strength and tone were normal. Deep tendon reflexes
2 were normal at 2+, motor strength was 5/5 at the bilateral lower extremity flexors and extensors.
3 A straight leg raise was normal at 75 degrees bilaterally. Dr. H.K. conditioned epidural injections
4 on the approval of patient B.P.'s psychiatrist.

5 (3) On or about December 23, 2008, patient B.P. was again seen by respondent. No
6 physical examination, other than vital signs, was performed. Respondent noted that patient B.P.
7 "remains oppositional with regards to his treatment plan," and instructed patient B.P. not to
8 change his dosing schedule. There was no discussion or follow up regarding the x-ray of the
9 thoracic spine that was ordered on or about December 8, 2008. The assessment included low
10 back pain without radiculopathy and schizoaffective disorder. Respondent prescribed Morphine²
11 15 mg, tid, #50; and Oxycodone³ 5 mg, every 4 hours as needed, #80. No explanation or
12 discussion was documented regarding the reason of the addition of Morphine and Oxycodone to
13 the treatment plan.

14 (4) On or about January 5, 2009, patient B.P. was again seen by respondent. Patient
15 B.P. reported that "pain secondary to Chronic L-S back pain is well controlled with current
16 regimen," but rated his pain level at a 10 on a scale to 10. Respondent noted in the chart that
17 "Patient again informed that since he walked into the clinic he CANNOT be a 10." No
18 musculoskeletal examination was performed. A neurological examination revealed "He is alert
19 and oriented." A psychiatric examination resulted in findings that "[m]ood, memory, affect and
20 judgment normal." The assessment was low back pain without radiculopathy; bipolar disorder;
21 depressed, partial remission; amphetamine or psychostimulant dependence, in remission; and
22 cannabis dependence, in remission. The plan was "Refill medication." Respondent issued

23
24 ² "Morphine" is a Schedule II controlled substance from the opiates class, pursuant to Health and
25 Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section
26 1308.12, subdivision (b)(1)(ix), and is a dangerous drug pursuant to Business and Professions Code
27 section 4022.

28 ³ "Oxycodone" is a Schedule II controlled substance from the opiates class pursuant to Health and
Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section
1308.12, subdivision (b)(1)(xiii), and a dangerous drug pursuant to Business and Professions Code section
4022.

1 prescriptions for a 15-day time period from January 5-20, 2009, for Morphine 15 mg, tid, #50;
2 and Oxycodone 5 mg, every 4 hours prn, #80.

3 (5) On or about January 20, 2009, patient B.P. was seen by physician assistant J.C.⁴ No
4 neurological or back examination was performed, and the treatment plan was to continue the
5 Morphine and Oxycodone prescriptions. Respondent signed the chart note and indicated his
6 agreement with the assessment and plan on or about January 26, 2009.

7 (6) On or about February 13, 2009, patient B.P. was again seen by respondent. Patient
8 B.P. had run out of his opiates medication early. No physical examination, except for vital signs,
9 was performed. The assessment was schizoaffective disorder; low back pain without
10 radiculopathy; muscle spasms of back; cannabis dependence in remission; and amphetamine or
11 psychostimulant dependence in remission. The plan was to "Refill medication." Respondent
12 issued prescriptions for Morphine 30 mg, tid, #90; and Cyclobenzaprine 10 mg, tid as needed,
13 #100. Respondent did not document the rationale for doubling the dosage of Morphine from 15
14 mg tid, to 30 mg tid.

15 (7) On or about February 24, 2009, patient B.P. was again seen by respondent. Patient
16 B.P. reported he had already run out of the 30-day supply of opiates prescribed 11 days earlier.
17 Respondent copied verbatim the history portion of this chart note from the previous chart note.⁵
18 Respondent noted that patient B.P. had presented to the emergency department seeking a change
19 in his medications, and that "[p]atient, again, informed of the need to have only one doctor
20 controlling his pain meds." No physical examination was performed, except for a brief mental
21 status examination and vital signs. No review of systems involving musculoskeletal was
22 performed. Respondent again doubled the dosage of Morphine to 60 mg, tid, #65. Respondent
23 did not document the rationale for doubling the dosage of the Morphine, but during the Medical
24 ///

25 _____
26 ⁴ Respondent was the supervising physician of physician assistant J.C.

27 ⁵ During the Medical Board's investigative interview of respondent, he acknowledged that it was
28 his practice to "cut and paste" the history portion of his chart notes.

1 Board's investigative interview stated that his rationale in increasing the dosage of the narcotic
2 was to keep the patient "engaged in a nonpharmacologic program" and "[t]o keep 'em in our
3 clinic."

4 (8) On or about March 6, 2009, patient B.P. was again seen by respondent, who
5 presented with his mother. Respondent "confronted the patient with the recurring early requests
6 for refill and the fact that he sought medication from another physician," and "with this re-
7 emergence of Addictive behavior." Respondent noted that patient B.P. "seems indifferent to the
8 consequences." Respondent documented a normal mental status examination. No neurological
9 or back examination was performed. No review of systems involving musculoskeletal was
10 performed. The assessment was low back pain without radiculopathy; schizoaffective disorder;
11 cannabis dependence in remission; and amphetamine or psychostimulant dependence in
12 remission. The plan was to refill medications and return to the clinic in two weeks. Respondent
13 prescribed Fentanyl⁶ 50 mcg/hr, every 72 hours, #7. Respondent did not document any
14 explanation for adding Fentanyl to patient B.P.'s treatment.

15 (9) On or about March 20, 2009, patient B.P. was again seen by respondent. Patient B.P.
16 reported pain at a level of 4-5 on a scale to 10. Respondent noted under history that the pain was
17 secondary to lumbar disc disease with radiculopathy. No physical examination was performed,
18 except for a brief mental status examination, which was normal, and vital signs. Respondent's
19 assessment included low back pain without radiculopathy and schizoaffective disorder. The plan
20 was to refill medications. Respondent prescribed Fentanyl, with an increase in the dosage from
21 50 mcg/hr to 75 mcg/hr, every three days, #7. Respondent did not document any explanation for
22 the reason for increasing the dosage of the Fentanyl to 75 mcg/hr.

23 (10) On or about April 9, 2009, patient B.P. was again seen by respondent. Patient B.P.
24 reported that his pain was well-controlled by the current regimen, but complained that the
25 Fentanyl patches were falling off. His pain level was reported at 6-8 on a scale to 10. A review
26

27 ⁶ "Fentanyl" is Schedule II controlled substance pursuant to Health and Safety Code section
28 11055, subdivision (c), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision
(c)(9), and is a dangerous drug pursuant to Business and Professions Code section 4022.

1 of systems, which did not include musculoskeletal, was normal. No physical examination, except
2 for a brief mental status examination and vital signs, was performed. Assessments included low
3 back pain without radiculopathy and schizoaffective disorder. The plan was "Refill medication"
4 and to change to Methadone⁷ 30 mg, tid. Respondent did not document his rationale for
5 prescribing Methadone, but during the Medical Board's investigative interview, he said that
6 "Methadone is – is not a drug of abuse," "so I switched him to the least dangerous medication I
7 can give him as far as abusing it."

8 (11) On or about April 23, 2009, patient B.P. was again seen by respondent. The history
9 portion of the chart note was verbatim from the previous visit, including patient B.P.'s complaint
10 that the Fentanyl patches, which were no longer being prescribed to patient B.P., were falling off.
11 No physical examination, except for a normal brief mental status examination and vital signs, was
12 performed. The plan was "Refill medication" and return to the clinic in two weeks. Respondent
13 prescribed Methadone 10 mg, tid, #120. Respondent did not explain the rationale in changing the
14 dosage of Methadone.

15 (12) On or about May 20, 2009, patient B.P. was again seen by respondent. The history
16 was verbatim to the April 9 and 23, 2009, visits, including patient B.P.'s complaint that the
17 Fentanyl patches, which were no longer being prescribed, were falling off. No physical
18 examination was performed, except for a brief mental status examination which was normal. The
19 plan was to refill medication and return to the clinic in one month. Respondent prescribed
20 Methadone 10 mg, tid, #360.

21 (13) On or about July 13, 2009, patient B.P. was again seen by respondent. The history
22 was verbatim to previous office visits, including patient B.P.'s complaint that the Fentanyl
23 patches, which were no longer being prescribed, to patient B.P., were falling off. No physical
24 examination was performed, except for a normal brief mental status examination and vital signs.
25 The assessment was herniation of lumbar intervertebral disc with radiculopathy, low back pain

26 ⁷ "Methadone" is a Schedule II controlled substance from the opiates class pursuant to and Health
27 and Safety Code section 11055, subdivision (c), and Title 21 of the Code of Federal Regulations, section
28 1308.12, subdivision (c)(15), and is a dangerous drug pursuant to Business and Professions Code section
4022.

1 without radiculopathy, pain disorder associated with general medical condition and psychological
2 factors, cannabis dependence in remission, amphetamine or psychostimulant dependence in
3 remission, and personality disorder. There is no mention of any imaging studies to support the
4 new diagnosis of herniation of the lumbar disc with radiculopathy. The plan was to refill
5 medications and return to the clinic in one month. Respondent prescribed Methadone 10 mg, 4
6 tablets qid, #480. No explanation was documented for increasing the dosage of Methadone from
7 40 mg three times per day to 40 mg four times per day.

8 (14) On or about August 4, 2009, patient B.P. sent an email to respondent stating his pain
9 medication was not effective, despite patient B.P. having decided to increase his dosage of
10 Methadone 10 mg to 7 tablets per day.

11 (15) On or about August 7, 2009, patient B.P. was again seen by respondent. Respondent
12 noted that Methadone has been effective for pain, but the dosage needed to be increased. No
13 physical examination was performed, except for a normal brief mental status examination and
14 vital signs. The plan was to increase the dosage of Methadone 10 mg, to 7 tablets qid, totaling
15 280 mg per day, and return to the clinic in six weeks. Respondent prescribed Methadone 10 mg,
16 7 tablets qid, #1,260.

17 (16) On or about August 28, 2009, respondent prescribed Methadone 10 mg, 7 tablets
18 qid, #1,260, despite having prescribed a 45-day supply of Methadone three weeks earlier.
19 Respondent did not document an explanation for the early prescription.

20 (17) On or about September 21, 2009, patient B.P. was again seen by respondent.
21 Respondent noted "Patient having significant difficulty ambulating and is in unusual posture to
22 alleviate his back pain and the radicular pain." Patient B.P. stated he had an appointment with
23 physical medicine and rehabilitation, requested an MRI of the lumbar spine, and reported his pain
24 level at a 7-9 on a scale to 10. No physical examination was performed, except for a normal brief
25 status examination and vital signs. The assessment included herniation of lumbar intervertebral
26 disc with radiculopathy, schizoaffective disorder, and pain disorder associated with both general
27 medical condition and psychological factors. The plan was "Refill medication." Respondent
28 prescribed Methadone 15 mg, 1-2 tablets every 6 hours as needed, #100. Respondent did not

1 document an explanation for increasing the dosage of Methadone from 10 mg tablets to 15 mg
2 tablets.

3 (18) On or about October 26, 2009, respondent prescribed Methadone 10 mg, 7 tablets
4 qid, #1,260. Respondent did not document an explanation for the change in dosage from 15 mg
5 to 10 mg of Morphine.

6 (19) On or about October 28, 2009, patient B.P. was again seen by respondent.
7 Respondent copied verbatim the history from the September 21, 2009, chart note, including
8 patient B.P.'s statement he had an appointment with physical medicine and rehabilitation, the
9 patient's report that he requested an MRI of the lumbar spine, and the reported pain level at a 7-9
10 on a scale to 10. In addition to the copied/pasted information, respondent noted that patient B.P.
11 "changed the appointment" with physical medicine and rehabilitation, and was "exhibiting
12 pressured speech as well as low level delusions at work." Patient B.P. said he was refusing to talk
13 with psychiatry because his psychiatrist was "blocking his access to epidural steroids." No
14 physical examination was performed, except for a brief mental status examination and vital signs.
15 The assessment was herniation of the lumbar intervertebral disc with radiculopathy; pain disorder
16 associated with both general medication condition and psychological factors; schizoaffective
17 disorder; and bipolar I disorder, depressed, partial remission. The plan was "Refill medication."
18 Respondent prescribed Methadone 15 mg, 1-2 tablets every 6 hours as needed, #100.

19 (20) On or about November 23, 2009, patient B.P. was again seen by physician assistant
20 J.C. Physician assistant J.C. noted that patient B.P. reported his pain was unchanged and under
21 fair control with current medications. Patient B.P. reported low back pain at a level of 8 on a
22 scale to 10 that was nonradiating. No neurological or back examination was performed. The plan
23 was to continue medications. Physician assistant J.C. prescribed Morphine 15 mg, 1-2 tablets
24 every 6 hours as needed, #60, and Methadone 10 mg, 7 tablets qid, #420. On November 24,
25 2009, respondent electronically signed the chart note, indicating his agreement with the physician
26 assistant's assessment and plan.

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1 (21) On or about December 21, 2009, patient B.P. was again seen by respondent. Patient
2 B.P. complained of "inappropriate care," and respondent noted that patient B.P. was in denial of
3 the number of times that he was noncompliant with the treatment guidelines. No physical
4 examination was performed, except for a brief mental status examination and vital signs. There
5 was no follow-up regarding patient B.P.'s request for an MRI of the lumbar spine, as documented
6 in respondent's September 21, 2009, and October 28, 2009, chart notes. The plan was to refill
7 medication for two weeks and for the patient to make an appointment with his primary care
8 physician for a second opinion. Respondent prescribed Methadone 10 mg, 7 tablets qid, #420.

9 (22) On or about January 4, 2010, patient B.P. was seen by Dr. R.W. at the chronic pain
10 management clinic where respondent worked. Dr. R.W. noted that patient B.P. was carrying a
11 large guitar case, ambulating well, moving chairs and items in the examination room without
12 difficulty, and easily bent at the waist and lifted objects including his guitar case and chair.
13 Patient B.P. was asked about his compliance with the chronic pain management contract, and he
14 stated he had been taking up to 8 tablets per day of "his next door neighbor's" Dilaudid,⁸ that he
15 was smoking 2-4 bowls of marijuana per day, and that he had not been taking the prescribed
16 Methadone as directed but instead as patient B.P. "thought was appropriate." Patient B.P. stated
17 that he did not want to stop using marijuana and Dilaudid, did not want to attend CPMG meetings
18 /counseling, and that he did not want to attend psychiatric counseling or psychiatric appointments.
19 Patient B.P. further declined inpatient detoxification treatment, or treatment through Kaiser
20 Permanente's chemical dependency treatment program. Dr. R.W. attempted to perform a full
21 neurological examination, but was unable to perform a full neurological examination due to
22 patient refusal. Nor was Dr. R.W. able to perform a full physical examination due to "patient's
23 refusal to cooperate with examinations." Dr. R.W.'s assessment was history of back pain
24 complicated by recent history of THC and opioid abuse with signs of withdrawal, and smoking.
25 Dr. R.W.'s plan was to offer inpatient detoxification with psychiatric and medical care, which

26 ⁸ "Dilaudid" is a brand name for Hydromorphone, a Schedule II controlled substance from the
27 opiates class pursuant to Health and Safety Code section 11055, subdivision (b), and Title 21 of the Code
28 of Federal Regulations, section 1308.12, subdivision (b)(1)(vii), and a dangerous drug pursuant to
Business and Professions Code section 4022.

1 was declined, and to offer preventative medicine clinics for tobacco cessation, which was also
2 declined.

3 (23) On or about January 18, 2010, patient B.P. was again seen by respondent. Patient
4 B.P. stated that he was scheduled to have an epidural steroid injection and was told by the
5 anesthesiologist that he would have pain for one week following the injection. Respondent told
6 patient B.P. that post epidural pain is not standard, and directed him to discuss managing any pain
7 from the epidural with anesthesia. No physical examination was performed, except for a brief
8 mental status examination and vital signs. The assessment was herniation of the lumbar
9 intervertebral disc with radiculopathy, and pain disorder associated with both general medical
10 condition and psychological factors. There was no discussion regarding patient B.P.'s admitted
11 abuse of Dilaudid and marijuana, his admitted misuse of Methadone, or his failure to comply with
12 the pain management contract. The plan was to "Refill medication." Respondent prescribed
13 Methadone 10 mg, 7 tablets qid, #840.

14 (24) On or about February 16, 2010, patient B.P. was again seen by respondent.
15 Respondent noted under chief complaint "Patient states that his back pain is still significant.
16 When questioned, patient takes off on diatribe about fractionating the tyleenol [sic] from the
17 Hydrocodone and fighting with his brother and other delusional thinking." No physical
18 examination was performed, other than a brief mental status examination and vital signs. There
19 was no discussion regarding patient B.P.'s admitted abuse of Methadone, marijuana, and
20 Dilaudid, or patient B.P.'s refusal to comply with the pain management contract. The plan was
21 "Refill medication" and "Patient directed to follow up with psych provider." Respondent
22 prescribed Methadone 10 mg, 7 tablets qid, #840 and Morphine 15 mg, 1-2 tablets every 6 hours
23 as needed, #150. Respondent did not document his rationale for adding Morphine, which was not
24 a current prescription, in addition to Methadone.

25 (25) On or about March 15, 2010, patient B.P. was again seen by respondent. Patient
26 B.P. reported that his back pain was better, and rated it at a 5-7 on a scale to 10. No physical
27 examination was performed, except for a brief mental status examination and vital signs.
28 Respondent prescribed Morphine 15 mg, 1-2 tablets every 6 hours as needed; Methadone 10 mg,

1 7 tablets qid, and Diazepam⁹ 5 mg, every 8-12 hours as needed for muscle spasm. There was no
2 discussion regarding patient B.P.'s admitted abuse of Methadone, marijuana, and Dilaudid, or his
3 failure to comply with the pain management contract. There was no follow up regarding patient
4 B.P.'s direction to see his psychiatrist at the previous visit.

5 (26) On or about April 12, 2010, patient B.P. was again seen by respondent. The history
6 was verbatim to that of the previous visit. No physical examination was performed, except for a
7 brief mental status examination which was verbatim to the previous visit and vital signs. There
8 was no discussion regarding patient B.P.'s admitted abuse of Methadone, marijuana, and
9 Dilaudid, or his refusal to comply with the pain management contract. There was no follow up
10 regarding patient B.P.'s direction to see his psychiatrist as stated on the treatment plan on
11 February 26, 2010. The plan was "Refill medication." Respondent prescribed Methadone 10 mg,
12 7 tablets qid, #840; Morphine 15 mg, 1-2 tablets every 6 hours as needed, #240, and Diazepam, 5
13 mg, every 8-12 hours as needed, #60.

14 (27) On or about May 7, 2010, patient B.P. was again seen by respondent. Respondent
15 noted that patient B.P. was a 25-year-old male with a history of amphetamine and marijuana
16 dependence, that he had two active psychiatric issues – schizoaffective disorder and bipolar
17 disorder, and noted he has intermittent thought disorder and delusions. Respondent noted that
18 patient B.P. "has been seen a number of times for 'early' refills." Respondent wrote in the chart
19 that, "[Patient B.P.] is relatively (i.e. What constitutes a serious misuse of his medication versus
20 difficulty making the right decision due to thought process problems) stable on his current
21 medication regimen and it is my recommendation that no changes be made to that regimen." No
22 physical examination was performed, except for a brief mental status examination, which was
23 verbatim to the one documented from the previous visit, and vital signs. There was no discussion
24 regarding patient B.P.'s admitted abuse of Methadone, marijuana, and Dilaudid, or his failure to
25 comply with the pain management contract.

26 ⁹ "Diazepam" is a Schedule IV controlled substance from the benzodiazepine class pursuant to
27 Health and Safety Code section 11057, subdivision (d), and Title 21 of the Code of Federal Regulations,
28 section 1308.14, subdivision (c)(14), and is a dangerous drug pursuant to Business and Professions Code
section 4022.

1 (28) On or about June 1, 2010, Kaiser transferred respondent from the pain management
2 clinic to a different department. During the Medical Board's investigative interview, respondent
3 stated that this action was the result of a decision by upper level management that "all pain
4 patients did not need pain medication, that Cognitive Behavioral Therapy, teaching patients to
5 think about and respond to their pain in a different manner was all that was needed." Respondent
6 further explained that some of the patients with pain were transferred to a new integrated pain
7 management program, and that the treatment of others were turned over to their primary care
8 physician.

9 (29) On or about September 9, 2010, patient B.P. was seen by physician assistant C.L.
10 Physician assistant C.L. noted erratic behavior by patient B.P., including talking about multiple
11 subjects at the same time, kneeling under the exam table during the interview, and then leaving
12 the clinic in the middle of the interview and then returning to be seen again. Physician assistant
13 C.L. strongly encouraged patient B.P. to follow up with his psychiatrist, "but the patient became
14 upset and was not receptive to this idea." Physician assistant C.L. noted current cannabis abuse.
15 Physician assistant C.L. refused opiate therapy to patient B.P., "due to unstable psychiatric
16 problems and patient B.P. was not clear on how many Methadone he has been taking, his frequent
17 trips to UC [urgent care] for pain medication, chronic use of marijuana, and borrowing his
18 neighbors pain medication which he admitted to in the clinic today." Physician assistant C.L.
19 offered a referral to chemical dependency. About 20 minutes after patient B.P. had left the clinic,
20 the clinic was notified by security that he was laying in the hallway claiming he was in severe
21 pain "because I am passing a kidney stone." The security guard and physician assistant C.L.
22 "finally found [patient B.P.] in the bathroom after [an] extensive search, but patient refused to
23 leave the restroom, thus it was decided to call paramedics at 1726. After arrival of the first
24 responders patient left the bathroom but refused to be transferred to the ER, and then he left the
25 building." Physician assistant concluded the note, in bold-faced and underlined text, "**This**
26 **patient is not appropriate for chronic opiate therapy at this time.**"

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1 (30) On or about September 22, 2010, patient B.P. was again seen by respondent, who
2 had been transferred out of the pain management clinic to a different department. Respondent
3 informed patient B.P. that he could seek a same-day appointment with his primary care physician,
4 or go to urgent care or the emergency department.

5 (31) Respondent never consulted with patient B.P.'s psychiatrist while providing care to
6 patient B.P.

7 (32) Respondent committed gross negligence in his care and treatment of patient B.P.,
8 which included, but was not limited to, the following:

9 (A) Respondent failed to take or document taking a complete history from, or perform or
10 document performing an appropriate prior physical examination of, patient B.P. while prescribing
11 controlled substances to patient B.P. over an approximate 17-month period.

12 (B) Respondent failed to develop a treatment plan that outlined the goal of using the
13 medications and the directions taken throughout the course of treatment while prescribing
14 narcotic pain medications over a 17-month period.

15 (C) Respondent repeatedly increased the dosage of prescribed narcotics, or changed
16 patient B.P.'s narcotics regimen, without documenting a rationale for the changes in the
17 prescriptions.

18 (D) Respondent prescribed substantial increases in opiate drugs to patient B.P., without
19 performing appropriate periodic review of the treatment, without noting whether the plan was
20 being met, and without explaining modifications of the treatment based on the patient's progress
21 or lack of progress.

22 (E) Respondent did not maintain accurate or complete medical records demonstrating
23 the patient's medical history, social history, drug abuse and addiction history, follow-up
24 examinations, evaluations including consultations, and treatment plans and treatment objectives.
25 Respondent additionally employed a "copy and paste" practice of documenting the patient's
26 complaint, history, and mental status examination from previous office visits.

27 (F) Respondent failed to identify or appropriately treat patient B.P. for possible drug
28 abuse, drug dependence, or drug addiction, despite knowledge of the patient's past history of drug

1 abuse and dependence, and despite indications that the patient had a drug problem, but instead
2 continued to prescribe high dosages of Schedule II controlled substances, despite indications of
3 drug abuse or drug addiction.

4 (b) Patient E.F.

5 (1) Patient E.F. was initially seen by respondent on or about December 12, 2006.

6 Patient E.F. was a 59-year-old male who had a radical mastectomy to treat cancer in left breast in
7 August of 2004, followed by radiation and chemotherapy. Patient E.F. reported to respondent
8 that his post-radiation pain had increased over the previous year. No physical examination was
9 performed, except for vital signs noting that patient E.F. was 5'1", weighed 235 lbs., and had a
10 high blood pressure of 152/91, and a mental status check. No assessment was documented. The
11 plan was to prescribe Morphine 100 mg, 2 tablets tid; and Oxycodone 5 mg, 1-2 tablets every 6
12 hours as needed.

13 (2) On or about January 23, 2007, patient E.F. was again seen by respondent. Patient
14 E.F. reported that his pain was well controlled with the current regimen. Respondent performed
15 no physical examination, except for vital signs which included a high systolic blood pressure of
16 161/83, and a mental status check. The plan was "Dispense refill of medication." Respondent
17 prescribed Oxycodone 5 mg, 1-2 tablets every 6 hours as needed, #240, and Morphine 100 mg, 2
18 tablets tid, #200.

19 (3) On or about February 20, 2007, patient E.F. was again seen by respondent. Portions
20 of respondent's chart note, including the patient's history, mental status check, and plan, were
21 verbatim to the note from the previous visit. No physical examination was performed, except for
22 vital signs which included a high blood pressure of 164/94. Respondent prescribed Oxycodone 5
23 mg, 1-2 tablets every 6 hours as needed, #300; and Morphine 100 mg, 2 tablets tid, #200.

24 (4) On or about March 19, 2007, patient E.F. was again seen by respondent. Portions of
25 respondent's chart note, including the history, mental status check, and plan, were verbatim to the
26 previous visit. No physical examination was performed, except for vital signs which included a
27 high blood pressure of 150/100. Respondent prescribed Oxycodone 5 mg, 1-2 tablets every 4
28 hours as needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

1 (5) On or about May 15, 2007, patient E.F. was again seen by respondent. Portions of
2 respondent's chart note, including the patient's history, mental status check, and plan, were
3 verbatim to the note from the previous visit. No physical examination was performed, except for
4 vital signs which included a high blood pressure of 165/95. Respondent prescribed Oxycodone 5
5 mg, 1-2 tablets every 6 hours as needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

6 (6) On or about July 10, 2007, patient E.F. was again seen by respondent. Respondent
7 noted the chief complaint was "Post Radiation Pain and Post Herpetic Neuralgia." The history of
8 present illness states that the patient reported that pain from both conditions remained "stable"
9 secondary to pain medication, and that the patient would be seeing an oncologist later that month.
10 The degree or location of the pain was not documented. No physical examination was performed,
11 except for vital signs. The plan was "Refill medication." Respondent prescribed Oxycodone 5
12 mg, 1-2 tablets every 4 hours as needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

13 (7) On October 30, 2007, patient E.F. was again seen by respondent. No physical
14 examination was performed, except vital signs which included a high systolic blood pressure of
15 151/84. There was no identification of the degree or location of the complaint of pain. No
16 assessment was documented. There was no follow-up regarding patient E.F.'s report at the July
17 10, 2007, visit that he was scheduled to see an oncologist. The plan was "Refill medication
18 without [sic] change." Respondent prescribed Oxycodone 5 mg, 1-2 tablets every 4 hours as
19 needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

20 (8) On or about December 24, 2007, patient E.F. was again seen by respondent.
21 Respondent's chart note, including the complaint, mental status check, and plan was copied and
22 pasted from the previous visit. No physical examination was performed, except for vital signs
23 which included a high systolic blood pressure of 150/81. No assessment was documented.
24 Respondent prescribed Oxycodone 5 mg, 1-2 tablets every 4 hours as needed, #600; and
25 Morphine 100 mg, 2 tablets tid, #380.

26 (9) On or about June 10, 2008, patient E.F. was again seen by respondent. Patient E.F.
27 reported that his pain was well controlled, and rated the pain level at 4-5 on a scale to 10. Patient
28 E.F. said he had no new problems. The location of the pain was not documented. Patient E.F.

1 had a high systolic blood pressure of 159/85. Respondent documented normal psychiatric review
2 of systems and a normal psychiatric examination, but made an assessment of pain disorder with
3 psychological factors. Respondent also made an assessment of neuralgia,¹⁰ but failed to specify
4 the type of neuralgia, the date of onset, or location of the neuralgia. Despite the assessment of
5 neuralgia, respondent's only finding from his neurological examination was "He is alert and
6 oriented." The plan was to refill medication. Respondent prescribed Oxycodone 5 mg, 1-2
7 tablets every 4-6 hours as needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

8 (10) On or about August 5, 2008, patient E.F. was again seen by respondent. The history,
9 review of systems, physical examination, and plan were verbatim to the chart from the previous
10 visit. Patient E.F. had a high systolic blood pressure of 150/82. Respondent documented a
11 physical examination and review of systems that resulted in no abnormal findings. Respondent's
12 assessment was pain disorder with psychological factors, despite no abnormal psychological
13 findings or complaint, and postherpetic neuralgia¹¹, despite no abnormal findings from
14 respondent's purported neurological examination and examination of the skin. Respondent
15 prescribed Oxycodone 5 mg, 1-2 tablets every 4-6 hours as needed, #600; and Morphine 100 mg,
16 2 tablets tid, #380.

17 (11) On or about September 30, 2008, patient E.F. was again seen by respondent.
18 Respondent's chart note, including the history, review of systems, physical examination,
19 assessment and plan, was verbatim to his previous note. Patient E.F. had a high systolic blood
20 pressure of 148/74. Respondent's assessment was pain disorder with psychological factors,
21 despite no abnormal psychological findings or complaint, and postherpetic neuralgia, despite no
22 abnormal findings from respondent's purported neurological examination and examination of the
23 skin.

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26 ¹⁰ Neuralgia is pain from a damaged nerve.

27 ¹¹ Postherpetic neuralgia is pain caused by the shingles virus, and is typically confined to the skin
28 following a shingles outbreak in the same area of the skin.

1 (12) On or about November 24, 2008, patient E.F. was again seen by respondent.
2 Respondent's chart note, including the history, review of systems, physical examination,
3 assessment and plan, was verbatim to the previous visit. Patient E.F. had a high blood pressure of
4 178/92, which continued to go unidentified and untreated by respondent.

5 (13) On or about March 17, 2009, patient E.F. was again seen by respondent. The patient
6 reported pain secondary to postherpetic neuralgia as being well controlled, with a reported pain
7 level of 5 on a scale to 10. A brief mental status examination, with no abnormal findings, was
8 documented. No physical examination was performed, except for the brief mental status exam
9 and vital signs which included a high systolic blood pressure of 157/79. The assessment was pain
10 disorders with psychological findings and postherpetic neuralgia. Respondent again prescribed
11 Oxycodone 5 mg, 1-2 tablets every 4-6 hours as needed, #600; and Morphine 100 mg, 2 tablets
12 tid, #380.

13 (14) On or about May 15, 2009, patient E.F. was again seen by respondent. A normal
14 review of systems and a normal brief mental status examination, both of which were verbatim to
15 the chart note from the previous visit, was recorded. No physical examination was performed,
16 except for the brief mental status exam and vital signs which included a high systolic blood
17 pressure of 146/82. Respondent again prescribed Oxycodone 5 mg, 1-2 tablets every 4-6 hours as
18 needed, #600; and Morphine 100 mg, 2 tablets tid, #380.

19 (15) On or about July 16, 2009, patient E.F. was again seen by respondent. Respondent
20 documented a review of systems reporting no complaint that was verbatim to the previous visit.
21 A normal brief mental status examination, which was verbatim to the previous visit, was also
22 documented. No physical examination was performed, except for the brief mental status exam
23 and vital signs which included a high systolic blood pressure of 155/78. Respondent again
24 prescribed Oxycodone 5 mg, 1-2 tablets every 4-6 hours as needed, #600; and Morphine 100 mg,
25 2 tablets tid, #380.

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1 (16) On or about August 27, 2009, patient E.F. was again seen by respondent. The
2 patient reported no new problems since the previous visit, and a review of systems was normal in
3 all areas. Respondent noted a normal brief mental status exam, which was verbatim to the brief
4 mental status exams documented in previous visits. No other physical examination was
5 performed, except for vital signs which included a high systolic blood pressure of 162/85. The
6 assessment was postherpetic neuralgia, diabetes mellitus type 2, and pain disorder with
7 psychological factors. The plan was to "Refill medication" and return to the clinic in three
8 months. Respondent prescribed Morphine 100 mg, 2 tablets tid, #380, totaling a 63-day supply,
9 and Oxycodone 1-2 tablets every 6 hours as needed, #600, totaling a 75-day supply.

10 (17) On or about September 11, 2009, respondent prescribed to patient E.F., Morphine
11 100 mg, 2 tablets tid, #380; and Oxycodone 5 mg, 1-2 tablets every 6 hours as needed, #600,
12 despite the fact that he had already prescribed a 63-day supply of Morphine and a 75-day supply
13 of Oxycodone 15 days earlier.

14 (18) On or about November 19, 2009, patient E.F. was again seen by respondent.
15 Respondent noted a normal brief mental status exam, which was verbatim to the brief mental
16 status exams documented in previous visits. No other physical examination was performed,
17 except for vital signs. The assessment was postherpetic neuralgia, and pain disorder with
18 psychological factors. The plan was "Refill medications." On or about November 21, 2009,
19 respondent prescribed Morphine 100 mg, #360, and Oxycodone 5 mg, #600.

20 (19) On or about January 22, 2010, patient E.F. was again seen by respondent.
21 Respondent noted a normal brief mental status exam, which was verbatim to the brief mental
22 status exams documented in previous visits. No other physical examination was performed,
23 except for vital signs which included a high systolic blood pressure of 174/80. The assessment
24 was postherpetic neuralgia, and pain disorder with psychological factors. The plan was "Refill
25 medications." Respondent prescribed Morphine 100 mg, #360, and Oxycodone 5 mg, #600.

26 (20) On or about March 19, 2010, patient E.F. was again seen by respondent. The history
27 was verbatim to the previous visit. Respondent noted a normal brief mental status exam, which
28 was verbatim to the brief mental status exams documented in previous visits. No other physical

1 examination was performed, except for vital signs which included a high systolic blood pressure
2 of 155/83. The assessment was postherpetic neuralgia, and pain disorder with psychological
3 factors. The plan was "Refill medication." Respondent prescribed Morphine 100 mg, #360, and
4 Oxycodone 5 mg, #600.

5 (21) On or about May 14, 2010 patient E.F. was again seen by respondent. Respondent
6 noted a normal brief mental status exam, which was verbatim to the brief mental status exams
7 documented in previous visits. No other physical examination was performed, except for vital
8 signs which included a high systolic blood pressure of 155/75. The assessment was postherpetic
9 neuralgia, and pain disorder with psychological factors. The plan was "Refill medication."
10 Respondent prescribed Morphine 100 mg, #360, and Oxycodone 5 mg, #600.

11 (22) Respondent never identified or treated patient E.F. for high blood pressure, and he
12 never informed patient E.F.'s primary care physician about patient E.F.'s high blood pressure.

13 (23) Respondent committed gross negligence in his care and treatment of patient E.F.,
14 which included, but was not limited to, the following:

15 (A) Respondent repeatedly failed to take or document taking a complete history from, or
16 to perform or document performing an appropriate prior examination of, patient E.F. while
17 prescribing controlled substances to him.

18 (c) **Patient R.D.**

19 (1) On or about January 21, 2009, patient R.D. was seen by physician assistant J.C.
20 Physician assistant J.C. noted that patient R.D. had been "kicked out" of the pain management
21 program in Fontana "due to threatening behavior and noncompliance," that patient R.D. had a
22 history of storing drugs and taking high dosages at once, had a past history of methamphetamine
23 use, and that he acknowledged that he had saved some of his pain medications for his dog.
24 Patient R.D. stated that he "just got off track with PCP [primary care physician] re: issues related
25 to pain meds." On or about January 30, 2009, after talking to clinic manager Dr. R.V., physician
26 assistant J.C. decided to transfer patient R.D.'s care to respondent because "due to [the]
27 complexity of pt's case, [she] believe[d] this is a case more appropriate for md vs pa."

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1 (2) On or about February 19, 2009, patient R.D. was initially seen by respondent.
2 Respondent documented that the patient reported pain secondary to degenerative disc disease.
3 There was no history of present illness documented, including the location of the back pain, date
4 of onset, or frequency of back pain. No history of back surgeries was documented. No history of
5 drug addiction, dependence, or abuse was documented. Patient R.D.'s psychiatric history was not
6 documented. No physical examination was performed, except for a brief mental status exam and
7 vital signs. The patient's weight was not recorded. The assessment was obesity and post-
8 laminectomy syndrome¹² of lumbar region. The plan was "Refill medication." Respondent
9 prescribed Morphine SR 60 mg, 2 tablets tid, #180, and Morphine 30 mg, 1-2 tablets every 6
10 hours as needed, #200.

11 (3) On or about April 17, 2009, patient R.D. was again seen by respondent. Patient R.D.
12 stated that his pain was well controlled with the current regimen, that he had no new problems,
13 and "[p]atient only wishes to receive refill for pain management medication." No physical
14 examination was performed, except for a normal brief mental status exam that was verbatim to
15 the previous visit, and vital signs. The assessment was post-laminectomy syndrome of the lumbar
16 region; depression, major, recurrent, moderate; and obesity. The plan was "Refill medication" and
17 return to the clinic in one month. Respondent prescribed Morphine sustained release 60 mg, 2
18 tablets tid, #180; Morphine 30 mg sustained release, tid, #250; and Morphine 30 mg, 1-2 tablets
19 every 6 hours as needed, #90. No explanation for the increase in dosage of Morphine was
20 documented.

21 (4) On or about May 15, 2009, patient R.D. was again seen by respondent. Respondent
22 documented a normal review of systems and brief mental status exam, both of which were
23 verbatim to the previous visit. No physical examination was performed, except for the brief
24 mental status exam and vital signs, which included a blood pressure of 163/99. The assessment
25 was post-laminectomy syndrome of lumbar region; depression, major, recurrent, moderate; and
26 obesity. The plan was "Refill medication." Respondent prescribed Morphine SR 60 mg, 2 tablets

27 ¹² Post-laminectomy syndrome, also called failed back syndrome, is a condition characterized by
28 persistent pain following back surgeries.

1 tid, #180; Morphine 30 mg SR, tid, #250; and Morphine 30 mg, 1-2 tablets every 6 hours as
2 needed, #90.

3 (5) On or about June 12, 2009, patient R.D. was again seen by respondent. Respondent
4 documented a normal review of systems and brief mental status exam, both of which were
5 verbatim to the previous visit. No physical examination was performed, except for the brief
6 mental status exam and vital signs. The assessment was post-laminectomy syndrome of lumbar
7 region; depression, major, recurrent, moderate; and obesity. The plan was to refill medication
8 and return to the clinic in one month.

9 (6) On or about July 9, 2009, patient R.D. was again seen by respondent. Respondent
10 noted that, "Patient states that pain secondary to Degenerative Disc Disease -- Lumbar and Spinal
11 Stenosis." Respondent documented a normal review of systems and a normal brief mental status
12 examination, both of which were verbatim to the charts for the previous visits. No physical
13 examination was performed, other than the brief mental status exam and vital signs. The
14 assessment was degeneration of the lumbar or lumbosacral intervertebral disc; post-laminectomy
15 syndrome of lumbar region; depression, major, recurrent, moderate; and obesity. The plan was to
16 refill medications and return to the clinic in two months. Respondent prescribed Morphine SR 60
17 mg, #360, Morphine SR 30 mg, #180, and Morphine IR 30 mg, #500.

18 (7) On or about September 3, 2009, patient R.D. was again seen by physician assistant
19 J.C. No physical examination was performed, other than a brief mental status exam and vital
20 signs. The assessment was pain disorder associated with both general medical condition and
21 psychological factors; degeneration of lumbar or lumbosacral intervertebral disc; post-
22 laminectomy syndrome of lumbar region; smoker; obesity; alcohol abuse; counseling on smoking
23 cessation; drug abuse; and spinal stenosis. The plan was to continue medications. On or about
24 September 22, 2009, respondent co-signed the chart note indicating he reviewed and agreed with
25 the assessment and plan.

26 (8) On or about December 18, 2009, patient R.D. was again seen by respondent. No
27 history, review of systems, physical examination or treatment plan was performed or documented.
28 The assessment was post-laminectomy syndrome of lumbar region, spinal stenosis, chronic low

1 back pain, degeneration of lumbosacral intervertebral disc, and pain disorder associated with both
2 general medical condition and psychological factors. Respondent prescribed Morphine SR 30
3 mg, #180; Morphine SR 60 mg, #360; and Morphine IR 30 mg, #500. During the Medical
4 Board's investigative interview, respondent confirmed that there was an office visit on this date,
5 but surmised that he forgot to write a chart note.

6 (9) On or about February 18, 2010, patient R.D. was again seen by respondent. No
7 physical examination was performed, except for a normal brief mental status exam, and vital
8 signs. Respondent documented a normal review of systems, which was verbatim to previous
9 chart notes. Despite the fact that, on or about February 4, 2010, physician assistant J.C. had
10 prescribed Morphine SR 30 mg, #180, Morphine IR 30 mg, #500, and Morphine SR 60 mg, #360,
11 no current medications were listed in the chart note.

12 (10) On or about April 15, 2009, patient R.D. was again seen by respondent. No physical
13 examination was performed, except for a normal brief mental status exam and vital signs.
14 Respondent documented a normal review of systems, which was verbatim to previous chart notes.
15 Despite the fact that, on or about April 1, 2010, physician assistant J.C. had prescribed Morphine
16 SR 30 mg, #180, Morphine IR 30 mg, #500, and Morphine SR 60 mg, #360, no current
17 medications were listed in the chart note.

18 (11) On or about May 13, 2010, patient R.D. was again seen by respondent. The history,
19 brief mental status exam, and review of systems, were copied and pasted, verbatim, from the
20 previous office visit. Respondent noted that the patient reported no new problems and wished to
21 receive a refill for pain medication. No physical examination was performed, except for a normal
22 brief mental status exam, which was verbatim to previous chart notes, and vital signs. The plan
23 was to refill medication. Respondent prescribed a 60-day supply of Morphine SR 30 mg, tid,
24 #180; Morphine IR 30 mg, 1-2 tablets every 6 hours as needed, #500; and Morphine SR 60 mg, 2
25 tablets tid, #360, despite the fact that respondent had already prescribed a 60-day supply of these
26 same narcotics less than a month earlier. In addition, respondent prescribed Norco (Hydrocodone
27 10 mg / Acetaminophen 325 mg), #60. No explanation was documented for the addition of
28 Norco, which was not a current prescription for patient R.D.

1 (12) Respondent treated patient R.D. using high dosages of Morphine, a Schedule II
2 controlled substance, for pain from post-laminectomy syndrome of the lumbar region, spinal
3 stenosis, degeneration of the lumbar or lumbosacral intervertebral disc, for approximately 15
4 months, without having ever performed an appropriate prior physical examination of patient
5 R.D.'s back, without having ever ordered or reviewed any imaging studies, without having ever
6 discussed any alternative to opioid therapy, and without having ever ordered a urine drug test to
7 ensure patient R.D. was not diverting the narcotics or taking other narcotics not prescribed.

8 (13) Respondent treated patient R.D. using high dosages of Morphine, without ever
9 documenting the patient's current or past history of drug and alcohol abuse and/or addiction.

10 (14) In June of 2010, Kaiser transferred patient R.D. from respondent's care.

11 (15) On or about August 13, 2010, patient R.D. was seen by Dr. R. W. Dr. R.W.
12 performed a back examination, and found "no CVA tenderness [costovertebral angle tenderness],
13 no scoliosis bilaterally, negative straight leg test bilaterally." The assessment was history of
14 chronic back pain complicated by history of dependence, major depression stable; history of
15 dependence in remission without signs of intoxication/withdrawal; and smoker. The plan
16 included dual diagnosis treatment counseling, attend 12-step meetings at least once per week with
17 signed care documenting attendance; and decreasing Morphine IR and Morphine SR dosages.

18 (16) Respondent did not take precautions to reduce the risks of high dosages of opiates
19 treatment, such as a sleep study or referral for specialist consultation, while prescribing high
20 dosages of opiates to patient R.D., who had morbid obesity and a known history of sleep apnea.

21 (17) Respondent committed gross negligence in his care and treatment of patient R.D.,
22 which included, but was not limited to, the following:

23 (A) Respondent repeatedly failed to take or document taking a complete history from, or
24 to perform or document performing an appropriate prior physical examination of, patient R.D.
25 while prescribing controlled substances to him.

26 (B) Respondent failed to perform an appropriate periodic review, including
27 documentation of the success or failure of the opiate treatment and the reasons for changes to the
28 opiate prescriptions.

1 (C) Respondent failed to consider whether patient R.D.'s sleep apnea was properly
2 managed, or to take steps to reduce the risk of high dosage opiates treatment to a patient with
3 morbid obesity and a known history of sleep apnea.

4 (d) Patient C.B.

5 (1) On or about May 26, 2009, patient C.B. was seen by respondent for the first time.
6 Patient C.B. stated she had a three-year history of ulceration of the lower extremities. Patient
7 C.B. reported her level of pain at 8-9 on a scale to 10. The pain was distributed to the lower
8 extremity only. The patient also reported chest pain, palpitations and leg swelling, but there was
9 no apparent follow-up regarding these complaints. A physical examination resulted in no
10 abnormal findings. No examination of the legs was performed or documented. The assessment
11 was ulcer of the lower limb and peripheral edema. The plan was Fentanyl, 75 mcg/hr, titrate
12 Neurontin, betadine wet-to-dry, and return to the clinic in two weeks.

13 (2) On or about June 4, 2009, patient C.B. was again seen by respondent. Patient C.B.
14 reported her pain level at 7-9 on a scale to 10. An examination of her legs showed ulcers treated
15 with wet-to-dry dressing were improved over the remainder of the leg. The plan was "Refill
16 medication" and return to the clinic in one month. Although not previously prescribed, and not a
17 part of the treatment plan, respondent prescribed Norco (Hydrocodone 10 mg /Acetaminophen
18 325 mg), 1-2 tablets every 6 hours as needed, #100. Respondent also prescribed Fentanyl 75
19 mcg/hr, every 72 hours, #5.

20 (3) On or about June 17, 2009, respondent prescribed Norco (Hydrocodone 10 mg /
21 Acetaminophen 325 mg), #200, and Fentanyl 75 mcg/hr, #10 to patient C.B. Respondent issued
22 these prescriptions only 13 days after he had prescribed a 30-day supply of the same narcotics,
23 without documenting any explanation for doing so.

24 (4) On or about June 18, 2009, patient C.B. was again seen by respondent. The history,
25 review of systems, brief status exam, assessment, and plan were verbatim to that from the
26 previous office visit. Physician assistant J.C. also included a note dated June 18, 2009, which
27 stated that patient C.B. reported that she was not taking as much Norco due to GERD, and
28 complained of occasional jerkiness/spasms in her legs.