

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

In the Matter of the Accusation )  
Against: )  
)  
)  
ANDREW GREGORY MONROY, M.D. ) Case No. 03-2010-207456  
)  
Physician's and Surgeon's ) OAH No. 2015010784  
Certificate No. A 69536 )  
)  
Respondent )  
\_\_\_\_\_ )

DECISION

The attached Proposed Decision 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 July 24, 2015.

IT IS SO ORDERED June 25, 2015.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD  
Dev Gnanadev, M.D., Chair  
Panel B

BEFORE THE  
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STATE OF CALIFORNIA

In the Matter of the Accusation Against:

ANDREW GREGORY MONROY, M.D.

Physician's and Surgeon's Certificate  
No. A 69536

Respondent.

Case No. 03-2010-207456

OAH No. 2015010784

**PROPOSED DECISION**

Administrative Law Judge David L. Benjamin, State of California, Office of Administrative Hearings, heard this matter on April 27-30, 2015, in Oakland, California.

Deputy Attorney General Brenda P. Reyes represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Michael A. Firestone, Attorney at Law, represented respondent Andrew Gregory Monroy, M.D., who was present.

The matter was submitted on April 30, 2015.

**FACTUAL FINDINGS**

1. On August 13, 1999, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number A 69536 to respondent Andrew Gregory Monroy, M.D. The certificate was in full force and effect during all of the events at issue in this matter. Respondent currently holds a Temporary License issued pursuant to Family Code section 17250, with an expiration date of July 6, 2015. There is no history of discipline against respondent's certificate.

2. On May 30, 2012, Linda K. Whitney, acting in her capacity at that time as the Executive Director of the Board, issued an accusation against petitioner. (Kimberly Kirchmeyer is now the Board's Executive Director.) Respondent filed a notice of defense and this hearing followed.

3. To summarize a lengthy pleading, the accusation alleges that respondent was grossly negligent or incompetent in his care of two patients with chronic pain syndrome, to whom he prescribed escalating doses of opioids; that he closed his office without notice to his patients, and then failed to make himself available to his patients to assist them with their medical needs; that he failed to timely provide his patients with copies of their medical records; and that he failed to maintain adequate and accurate records. Respondent acknowledges that his handwritten chart notes can be difficult for other people to read; otherwise, he denies the substance of the allegations.

*Respondent's professional background*

4. Respondent graduated from the University of California, Santa Barbara, in 1991 with a bachelor's degree in biological science, and earned his medical degree from the University of Southern California in 1998. From 1997 to 1998, he did an internship at Santa Barbara Cottage Hospital, and from 1998 to 2001 he did a residency in Physical Medicine and Rehabilitation with the Veterans Administration at the West Los Angeles Medical Center. Respondent states that he did a fellowship at the LAGS Spine and Sports Care Medical Center, Inc., from 2001 to 2002. That medical center was one of several on the central coast owned by Francis P. Lagatudda, M.D. Respondent states that in or around December 2004, Dr. Lagatudda "gave" him one of those centers, the Central Coast Spine and Pain Management Center located at 310 South Halcyon Road in Arroyo Grande. Respondent owned and operated that facility until late 2010. At the facility, respondent specialized in physical medicine, rehabilitation, and interventional pain management.

*Expert opinion*

5. This case presents issues as to the standards of care in the treatment of patients with chronic pain syndrome; a physician's competence; a physician's obligations to his patients, particularly his patients for whom he has prescribed opioids for pain management, when the physician closes his office; and a physician's duty to maintain adequate and accurate records. These are matters beyond the common knowledge of lay persons, and therefore matters on which expert medical opinion is required.

6. C. Edward Anderson, Jr., M.D., testified at the request of complainant. Dr. Anderson graduated from Pacific Union College in 1974 with a bachelor of science degree in biology, and earned his medical degree from Loma Linda University in 1979. He did a residency in anesthesiology at the same institution from 1979 to 1982. Dr. Anderson has spent his entire career in anesthesiology and pain management. He is board certified in anesthesiology (1987) and pain medicine (1995), with a subspecialty certification in pain management (1996, recertified in 2007). In 2006, Dr. Anderson was certified by the American Board of Interventional Pain Physicians. In 1997, he founded the Desert Pain Care Medicine Group in Palm Springs, a multiple-practitioner pain practice that sees 200 to 250 new patients per month with conditions ranging from musculoskeletal pain to cancer; Dr. Anderson is currently the chief executive officer of that group. All of the patients Dr.

Anderson treats are pain patients; he practices interventional pain management up to and including implantable devices.

7. Dr. Anderson reviewed respondent's records for the two patients whose treatment is at issue; reviewed the transcript of respondent's interview with Board investigators, which was held on May 24, 2011; reviewed other documents submitted to him by the Board; and prepared six written reports. He also testified at hearing. Dr. Anderson's testimony was clear and straightforward. He explained the basis for his opinions, and his reasoning was deliberate and thoughtful. He demonstrated a willingness to reconsider his opinions in light of new information. Dr. Anderson's testimony was credible in all respects.

8. Although respondent testified on his own behalf, he did not call an expert witness.

9. Insofar as respondent's opinions differ from those of Dr. Anderson, Dr. Anderson's opinions were persuasive. Dr. Anderson has far greater experience than respondent; he has board certifications directly relevant to the matters at issue that respondent lacks; and Dr. Anderson set forth a clear and persuasive basis for his opinions, grounded in patient protection. Unlike Dr. Anderson, respondent has a personal interest in the outcome of this case. Dr. Anderson's opinions are persuasive, and they establish the basis for all of the factual findings on which medical expertise is required.

*The Board's 1994 and 2007 Guidelines*

10. The Board's "Guidelines for Prescribing Controlled Substances for Pain," adopted in 1994 and revised in 2007, are the standard of care for prescribing opioids to treat chronic pain. It is the standard of care for a physician to:

- elicit an appropriate history from the patient, to perform an adequate physical examination, and to refer the patient to consultants, where appropriate;
- establish a treatment plan which states the objectives by which the success of the treatment plan can be evaluated, such as by pain relief and/or by improved physical and psychosocial function;
- obtain informed consent after counseling the patient on the risks and benefits of opioids;
- periodically review the course of pain treatment in light of any new information, and to reassess the continued use of opioids if the patient's progress is not satisfactory;
- consult with other professionals to achieve the treatment objectives, with special attention to patients who are at risk of misusing their medications; and

- keep and maintain accurate and complete records, including “the medical history and physical examination, . . . treatment plan objectives, informed consent, . . . rationale for changes in the treatment plan or medication, agreements with the patient, and periodic reviews of the treatment plan.”

### *Treating patients with chronic pain syndrome*

11. Chronic pain syndrome is a recognized diagnosis of a medical condition. The use of opioids for a patient with chronic pain syndrome requires special, careful attention by a physician. The diagnosis of chronic pain syndrome describes a patient with major psychological issues that accompany his or her complaints of pain. Treatment of a patient with chronic pain syndrome requires a three-part approach: 1) the physician must treat the patient with something for his or her pain, preferably avoiding substances that stimulate addiction; 2) the physician must provide psychological supports; and 3) the physician must provide a rehabilitation approach based on the patient’s function, not on the patient’s complaints of pain. Because of the overlay of psychological issues, the self-report of pain from a patient with chronic pain syndrome is not a reliable basis to establish a treatment plan, or to measure the success of a treatment plan. A report of pain at a level “10,” where 10 represents the worst imaginable pain, must be viewed skeptically when reported by a patient in an office visit, as opposed to an emergency room setting. By the same token, the patient’s self-report of pain is not a reliable way to assess whether the patient is improving under the physician’s care. Rather, the success of the treatment plan must be assessed based on the patient’s function.

### *Medications*

12. Respondent prescribed the following drugs to S.A. and E.L., the two patients whose treatment is at issue in this case.<sup>1</sup> They are all dangerous drugs and controlled substances as defined by state law and federal regulation.<sup>2</sup>

Actiq is a trade name for oral transmucosal fentanyl citrate; it comes in the form of a lozenge. Fentanyl is an opioid analgesic. It is prescribed for breakthrough pain for cancer patients, as it is rapidly absorbed and provides a sudden surge of opiate. “Breakthrough pain” is pain above and beyond the patient’s daily pain. Actiq is not commonly prescribed to patients with chronic pain.

Dilaudid is a trade name for hydromorphone hydrochloride. Dilaudid is hydrogenated ketone morphine and it is a narcotic analgesic.

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<sup>1</sup> Initials are used to protect the patients’ privacy.

<sup>2</sup> See Business and Professions Code section 4022; Health and Safety Code sections 11055, 11056 and 11057; and 21 Code of Federal Regulations parts 1308.12, 1308.13 and 1308.14.

Duragesic is a trade name for a fentanyl transdermal system; it is a long-acting opioid worn as a patch.

Kadian, MS Contin and MSIR are all trade names for morphine. "MSIR" stands for morphine sulfate immediate release. It is a long-acting form of morphine, as is MS Contin.

Norco is a trade name for hydrocodone bitartrate with acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic.

Opana is a trade name for oxymorphone hydrochloride. Oxymorphone hydrochloride is a semisynthetic opioid analgesic.

OxyContin is a trade name for oxycodone hydrochloride controlled release tablets. It is an opioid analgesic.

Percocet is a trade name for a combination of oxycodone hydrochloride and acetaminophen. It is a semisynthetic narcotic analgesic.

Restoril is a trade name for temazepam, a hypnotic agent.

Soma is a trade name for carisoprodol tablets. It is a muscle relaxant.

Valium is a trade name for diazepam. It is used to treat anxiety.

Xanax is a trade name for alprazolam tablet. It is also used to treat anxiety.

#### *Patient S.A.*

13. S.A. was referred to respondent by her primary care physician, who described her condition as hemochromatosis (iron overload, a condition not associated with pain), and chronic hip joint pain. At her first visit on March 5, 2007, S.A. filled out a new patient questionnaire on which she reported constant, burning pain in her low back on the right side, pain on the back of her right leg from the knee to the foot, and low back pain. The questionnaire asked S.A. to rate her pain on a scale of 1 to 10, with 10 being "intolerable pain." She reported her pain as "10," and stated that it began in 2003. S.A. reported that she could sit and stand for 30 minutes, and walk for 15 minutes. She told respondent that her current medications included Percocet for pain, which "did not do anything for [her]," Xanax for agoraphobia, a Lidoderm patch (a local anesthetic), and Seroquel for a sleep disorder.

Respondent prepared a report of his initial examination; the report is printed, as opposed to handwritten like most of his subsequent progress notes. He noted that S.A.'s gait was essentially normal. He diagnosed her condition as

Chronic Pain Syndrome  
Lumbar Degenerative Disc Disease  
Hip Bursitis

Under "Discussion," respondent wrote, "X-ray series of the lumbar spine/right hip recommended. Medical cannabis recommended. Prescriptions as directed. Dilaudid 4mg 1 po tid prn. Consider right lower extremity EMG." The report does not establish a treatment plan for the use of opioids, or objectives by which the effectiveness of opioids will be evaluated. The report does not state that respondent obtained S.A.'s informed consent to the use of opioids. The report does not state the basis for the medical marijuana recommendation that respondent gave S.A. at her first visit.

14. After this initial visit, respondent saw S.A. about monthly until April 2010. At each appointment, S.A. completed a "Review of Systems" form identifying (among other things) her current complaints; how long she could sit, stand and walk; any new problems; her pain intensity on a scale of 1 to 10; and whether her pain was better or worse.

After each appointment, respondent completed a "Physician Report." He used preprinted forms with labeled boxes for the physician's entries. The form includes a box labeled "Physician Exam," with places for the physician to record the patient's present complaints and the physician's objective findings. There are lines for the physician to report his diagnoses. And there is a box titled "Treatment Plan." The form directs the physician to "[i]nclude treatment rendered to date. List methods, frequency, and duration of planned treatment. Specify consultation referral . . . . Have there been any changes in treatment plan? If so, why?" Some of respondent's reports are printed and readable; most are handwritten. Respondent's entries on his handwritten reports are brief and, for the most part, illegible and unintelligible.

15. S.A. returned to respondent on March 20, 2007. Her x-rays were unremarkable, but the x-ray of the lumbar spine revealed a "very large amount of retained fecal material throughout the colonic loops." Constipation is a known side effect of the use of opioids. This finding should have raised a concern that S.A. was developing toxic megacolon, a potentially serious condition. Respondent's reports of his visits with S.A. on April 2 and April 27, which are typewritten and readable, do not reveal any discussion with claimant about this x-ray finding, its significance, or its effect on respondent's treatment. Respondent continued his prescriptions for #90 Dilaudid 4 mg., a month's supply.<sup>3</sup> There is no follow-up on these reports, or any subsequent reports, of respondent's consideration of an EMG.

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<sup>3</sup> The symbol "#" represents the number of pills, tablets, patches or lozenges prescribed, and that number typically represents a month's supply. Thus, "#90" contemplates that the patient will take three tablets per day, "#120" contemplates four per day, and so on.

16. On June 19, 2007, S.A. continued to complain of extreme, constant pain in the hips, which she rated as 10 and "90 percent" worse. Respondent increased the dose of Dilaudid from 4 mg. to 8 mg. (still #90), and added a prescription for Xanax, 1 mg. #60 prn. His handwritten progress note is brief, illegible and unintelligible.

17. On August 7, 2007, S.A. reported constant pain in her hips and right ankle, which she reported as 10 with no change despite treatment. Respondent increased Dilaudid 8 mg. to #120, and added #30 Soma 350 mg. In his progress report, there is no legible description of S.A.'s complaints, respondent's objective findings, or his treatment plan.

18. S.A. saw respondent on December 4, 2007. S.A. again reported constant pain bilaterally in her hips, calves and ankles, and pain in her neck, feet and right thumb. She stated that her pain was constant at a level of 10, with no change despite treatment. S.A. reported that she could only sit, stand or walk for 10 minutes, a decrease in her functional ability since her first visit eight months earlier. Respondent maintained her prescription for Dilaudid, and changed Soma to Valium. His progress note states that he decided to add MS Contin. In his brief progress note, there is no legible description of why he changed Soma to Valium, why a long-acting form of morphine was judged to be necessary, or why increasing amounts of controlled substances were being prescribed despite no improvement in S.A.'s subjective symptoms and a reported decrease in her functional abilities.

19. S.A. returned on January 15, 2008, and reported that, in addition to pain in her hips, ankles and calves, she had shingles. She rated her pain as 11 and stated that she could sit for only five minutes. S.A.'s pain chart does not describe a pattern consistent with shingles, and respondent's progress report appears to state "no lesions." Respondent issued S.A. a new medical marijuana recommendation, maintained her prescription for Dilaudid, added a 5 percent Lidoderm patch, and added 30 mg. Kadian, twice per day. Respondent's progress report is handwritten, brief and mostly illegible. There are no details of S.A.'s physical status, no explanations for the medical marijuana recommendation or the change in medications, and no readable treatment plan.

20. On April 15, 2008, S.A. reported musculoskeletal pain in various locations which she rated as constant at a level of 10, with no change in her pain level despite medications. Respondent refilled her prescriptions for Dilaudid and #60 Xanax XL 1 mg., added #20 Restoril 15 mg. and #60 Soma 350 mg., and discontinued Kadian and Valium. He gave S.A. prescriptions for #120 Dilaudid for May and June 2008. Respondent's handwritten progress report contains no legible description of S.A.'s complaints or his objective findings, and no legible treatment plan.

21. Respondent next saw S.A. on September 12, 2008. He refilled her prescriptions at the amounts prescribed in April. His records do not include a patient report. His progress report is handwritten and illegible.

22. S.A. returned on October 31, 2008, at which time she reported pain at a level of 10, and stated that her condition with treatment was "worse." Respondent's progress

notes for that day are handwritten and mostly illegible. At that visit, respondent obtained S.A.'s signature on a multi-page "Medical Treatment Contract" that set forth various items of "informed consent" and advised S.A. of respondent's discharge policies. This is the first documentation in S.A.'s chart that informed consent was obtained for opioid treatment. With respect to opioids, the medical treatment contract states that "[t]he risk of addiction, in patients who do not have a prior addiction history (to any substance) is extremely low." The medical literature has established that this statement is not true. The risk of addiction is significant even with patients who do not have a prior addiction history. In addition, respondent's informed consent document is deficient in that it fails to advise the patient of medical risks associated with the long-term use of opioids, including hypogonadism and cell reduction in bone marrow.

23. Throughout 2009, respondent saw S.A. about every month. She continued to report pain at a level of 10, or higher. On February 13, 2009, S.A. reported that her pain was at a level of 10 with medications and without medications. On May 8, she reported that her pain was at a level of 10 with medications, and 15 without. On June 11, S.A. stated that her pain was at 15 with medications, and 20 without. On August 4, September 3, and October 2, S.A. stated that her pain was a level 10 with and without medications.

During this time period, respondent prescribed increasing amounts of controlled substances to S.A.. On May 2, respondent added #60 Valium 5 mg. On October 2, respondent discontinued Restoril and Valium and added #60 MS Contin 30 mg. On October 30, respondent discontinued MS Contin and prescribed #240 Dilaudid 4 mg., #60 Xanax XL 1mg., and #60 OxyContin 60 mg. Respondent refilled these prescriptions at the same amounts through March 2010.

Respondent's progress reports during this period are brief and illegible. There is no legible discussion of S.A.'s clinical situation or her response to medications. There is no explanation of why OxyContin was added. There is no legible treatment plan, no legible statement of objectives, and no review of those objectives in light of S.A.'s periodic reports.

24. In May 2009, respondent had been treating S.A. for over two years. He had been prescribing increasing amounts of opioids, but S.A. was still complaining of constant, high levels of pain unaffected by medication; if anything, S.A. reported that her pain had increased during the time respondent was prescribing controlled substances for her. S.A.'s constant reports of pain at a level of 10 or higher may have been due to the psychological issues associated with chronic pain syndrome, or may have been due to "paradoxical hyperalgesic response" – an increase in pain with an increase in opiates – or it may have been drug-seeking behavior. Whatever the cause, it should have been clear to respondent that his treatment was failing, and that S.A. required a consultation with a psychologist or an addictionologist. Respondent never provided such a referral to S.A., and his assertion that no referral was necessary is not persuasive.

25. On April 23, 2010, respondent discharged S.A. from his practice. His chart does not state the basis for this decision. It does indicate, however, that he referred S.A. for

urine testing that day. The test results, issued on April 27, were negative for OxyContin and Dilaudid. These results are significant, as they indicate that S.A. was not taking the drugs respondent was prescribing, and raise the possibility that S.A. was diverting them. In his interview with Board representatives in May 2011, respondent stated that at S.A.'s last appointment she asked him for a backdated medical marijuana recommendation for her boyfriend, who had been arrested. Respondent stated that he considered S.A.'s request unethical, and had his staff call S.A. later that day to inform her that he was discharging her.

26. It is the standard of care to obtain and document a patient's informed consent to opioid treatment. Respondent did not document that he had obtained S.A.'s informed consent until October 31, 2008, 19 months after he began treating her, and his informed consent document improperly minimized the risk of addiction and failed to inform S.A. of the medical risks of long-term opioid treatment. Dr. Anderson persuasively testified that this was an extreme departure from the standard of care.

27. It is the standard of care to establish a treatment plan for a chronic pain patient, with objectives by which the success of the treatment plan can be measured. This standard is an essential foundation for prescribing opiates to treat patients with chronic pain, and it applies with particular significance in the treatment of patients with chronic pain syndrome. Without a clear treatment plan, the physician's goals for the patient cannot be determined, and the effectiveness of the treatment cannot be determined. Respondent did not document a treatment plan for S.A. at any time during the three years he cared for her. Dr. Anderson testified persuasively that this was an extreme departure from the standard of care.

Respondent testified that his treatment plan was to prescribe medications as necessary to relieve S.A.'s pain. That plan was never documented and, if it was respondent's plan, it did not conform to the standard of care. Respondent diagnosed S.A. as a patient with chronic pain syndrome. The self-report of pain by a patient with chronic pain syndrome is not a reliable basis on which to establish or measure the success of a treatment plan. A treatment plan must be based on improvement in the patient's function, not just decreasing the patient's self-report of pain.

28. It is the standard of care for a physician prescribing opioids for chronic pain to periodically review his treatment in light of new information, and to reassess the continued use of opioids in light of the patient's progress. Respondent did not follow-up on his initial suggestion of an EMG study. He did not follow-up on S.A.'s x-ray findings, which were unremarkable as far as her back was concerned, but which revealed a large amount of retained fecal material. During the three years respondent treated S.A., he did not conduct a periodic review of his pain treatment to support the increases in opioids that he prescribed. Dr. Anderson testified persuasively that this was an extreme departure from the standard of care.

Respondent testified that S.A.'s pain stayed at 10 because she developed a tolerance to the opiates at the level he prescribed. This contention is not persuasive. S.A.'s self-report of pain began at a level of 10, and she never reported any improvement in her condition

during the time respondent treated her. S.A.'s failure to improve was not an indication of tolerance.

29. It is the standard of care to order a consultation for a chronic pain patient when appropriate. Respondent diagnosed S.A. with chronic pain syndrome, and thus concluded that her reports of pain were associated with psychological factors. During the time that respondent treated her, S.A. reported constant, high levels of pain unaffected by continual increases in the amount of opioids prescribed. Dr. Anderson persuasively testified that, under these circumstances, respondent should have referred S.A. to a psychologist or an addictionologist to help him in the management of her case. In Dr. Anderson's opinion, respondent's failure to do so was an extreme departure from the standard of care, and his opinion is persuasive.

*Patient E.L.*

30. Patient E.L. was a 52-year-old woman when she saw respondent for the first time on October 23, 2006. On her patient questionnaire, E.L. stated that she had constant bilateral foot pain, worse on the left, and that on a scale of 1 to 10 her pain was an 8. She reported that she had had foot surgery in 2003 and had received "too many [treatments] to list" for this condition. E.L. wrote that she was under a doctor's care for diabetes mellitus and hypertension, and that she was currently taking Cymbalta (an antidepressant), Lamictal (an anticonvulsant), HCTZ (a drug used to treat fluid retention and hypertension), Percocet and Vicodin. With respect to her history, E.L. wrote that she was adopted, that she does not drink alcohol, and that she had a history of pain and depression.

31. In his initial evaluation, respondent wrote that E.L. was "negative for diabetes mellitus and hypertension." This was incorrect, as E.L. had stated on her intake questionnaire that she was under medical care for diabetes mellitus and hypertension. Respondent also wrote that E.L.'s family history was negative for "arthritis, cancer, back pain, neck pain, diabetes mellitus . . ." This, too, was incorrect, as E.L. had stated on her questionnaire that she was adopted and she did not offer a family history. Respondent's evaluation did not address peripheral neuropathy, a possible source of bilateral foot pain for a patient with diabetes, and did not set forth any details on respondent's 2003 foot surgery or her subsequent treatment. Respondent's evaluation did not identify the medications E.L. was taking.

Respondent diagnosed E.L. with chronic pain syndrome, lumbar degenerative disc disease, and status post foot fracture. Respondent prescribed #60 Kadian 20 mg., twice daily. Respondent did not state, in his initial evaluation or any subsequent report, what his treatment plan was for E.L.; what his treatment objectives were; or what measures he would use to establish the success of his treatment. He did not state how E.L.'s diabetes mellitus and hypertension might affect the treatment plan. Respondent did not document that he obtained E.L.'s informed consent before starting her on a course of treatment with opioids.

32. Respondent saw E.L. about monthly until April 2010. As was the case with patient S.A., some of respondent's progress notes are printed and legible. Most, however, are handwritten, and those notes are brief, illegible and unintelligible.

33. E.L. returned for follow-up on November 6, 2006, and complained of pain in both feet, her right hip, and her lower back. E.L. reported that she was taking more Kadian than respondent had prescribed, and that she was "out" of Percocet. Respondent prescribed #60 Kadian 30 mg., a higher dose than he had prescribed on November 6, and #120 Percocet 7.5/500 mg. Respondent's report of that appointment is brief and illegible. He ordered x-rays of the lumbar spine. The report does not address where E.L. had obtained the Percocet before November 6, E.L.'s failure to adhere to respondent's prescription for Kadian, or how this information affected respondent's treatment plan.

34. On November 28, E.L. reported that the Kadian made her sleepy and returned that medication to respondent. Respondent prescribed #150 Percocet.

35. On December 6, 2006, respondent recommended to E.L. that she see a podiatrist and that she do an aquatic program. Respondent prescribed #270 Percocet. His report contains no legible explanation for the increase in Percocet.

36. Respondent saw E.L. on December 28, 2006, and noted that x-rays of the low back had not been done, and that consultation with a podiatrist was pending. He added "neuropathy" to E.L.'s diagnoses. Respondent refilled #180 Percocet and gave respondent #60 samples of Lyrica 75 mg. (Lyrica is a trade name for pregabalin, an anticonvulsant medication also used to treat pain caused by nerve damage in patients with diabetes.)

37. On January 5, 2007, respondent performed a bilateral lumbar 3, 4 and 5 medial branch block on E.L.. Immediately after the procedure, E.L. reported no back pain. Two weeks later, on January 18, E.L. reported that her back pain was the same as it had been before the medial branch block, and that she was taking eight or nine Percocet per day. Respondent prescribed #60 MS Contin 30 mg. and #90 MSIR 30 mg. for breakthrough pain. His report does not state the rationale for this increase in E.L.'s medications, or set forth a review of his treatment plan.

38. On January 29, 2007, E.L. reported side effects from the MSIR and returned it to respondent. Respondent ordered lab tests. He prescribed #10 OxyContin 40 mg. On February 2, respondent refilled #180 Percocet 7.5/500 mg.

39. Respondent performed a second bilateral lumbar 3, 4 and 5 medial branch block on February 14, 2007. E.L. reported her post-operative pain as 0 out of 10. At her next appointment on March 5, 2007, E.L. reported that her pain was "better." Nevertheless, respondent prescribed #180 Percocet and added #90 Dilaudid 4 mg. as needed. Respondent's report does not state the rationale for adding Dilaudid after E.L. reported improvement in her level of pain.

40. On March 20, 2007, respondent prescribed #80 Percocet 7.5/500 mg. for E.L. There is no record that respondent saw E.L. on this day, and there is no explanation in respondent's chart for this prescription.

41. E.L. saw respondent on April 6, 2007. Respondent's brief progress note is illegible. There is no follow-up on the medial branch block, on the recommendation that E.L. see a podiatrist, or on the recommendation that she enroll in an aquatic program. At this time, respondent had been treating E.L., for six months with increasing doses of opiates with no treatment plan, and no periodic review to determine the effectiveness of the medications he was prescribing.

42. On May 3, 2007, E.L. came to her appointment with new complaints. She told respondent she had headaches due to a fall. Respondent's report of this appointment is printed. He increased the prescribed dose of Dilaudid from 4 mg. to 8 mg., prescribed #180 Percocet, and recommended four weeks of physical therapy.

43. E.L. returned to respondent on May 29, 2007, and reported pain in her feet, ankles and back which she described as "sometimes a 10." Respondent refilled #180 Percocet and #90 Dilaudid, both short-acting opioids, and added #10 Duragesic 50 mcg., a long-acting opioid. Respondent's progress note for this visit is not legible. There is no documentation of respondent's treatment plan or his reason for adding Duragesic, and there is no documentation that he obtained E.L.'s informed consent for this opiate regimen, which included the risk of respiratory depression.

44. On May 31, 2007, E.L. was treated in the emergency room at Arroyo Grande Community Hospital for a possible accidental overdose of pain medications. E.L. told the emergency room staff that she had a history of bipolar disorder, that she was taking Cymbalta (an antidepressant), and that she was a recovering alcoholic. The emergency room report states that, after she was seen by a physician but before her chemistry panel came back, E.L. signed out against medical advice. A copy of the emergency room report was sent to respondent and is included in E.L.'s chart.

45. Dr. Anderson testified, persuasively, that the emergency room report should have been a "raging red flag" to respondent that triggered a review of E.L.'s treatment. The report from the emergency room informed respondent that E.L. was taking Cymbalta, an antidepressant which she had not obtained from respondent; that she had a history of bipolar disorder; that she had a history of substance abuse; and that she had misused her medications, all matters that bore directly on E.L.'s risk of addiction and on respondent's continued prescription of opioids. In respondent's progress reports for the appointments with E.L. that followed, there is no indication that respondent discussed this emergency room visit with E.L. or that he reviewed his treatment plan in light of this information.

46. On June 20, 2007, respondent faxed to a pharmacy a prescription for #220 Norco 10/325 mg. for E.L. Respondent's records contain no explanation for this prescription. On July 13, 2007, respondent increased Norco to #300 without explanation.

On August 10, 2007, respondent increased Duragesic to #10 patches, 75 mcg., without explanation. On this date, respondent added "peripheral vascular disease" to his diagnoses, and recommended a "lumbar/diagnostic sympathetic block."

47. On August 22, 2007, respondent performed a left lumbar sympathetic nerve block on E.L. At a follow-up visit on August 30, 2007, E.L. reported no change in her condition. At this visit, respondent prescribed #240 Percocet and increased Duragesic to 100 mcg., #10. Respondent's report states no explanation for these increases in E.L.'s medications.

48. On September 21, 2007, respondent added #60 Opana IR (immediate release) 10 mg. to E.L.'s monthly prescription. His report states no explanation for adding this long-acting form of hydromorphone in light of his prescriptions for Duragesic and Norco.

49. Respondent administered trigger point injections to E.L.'s right lumbosacral paraspinal area on November 15, 2007. He prescribed #240 Percocet, and increased Opana IR 10 mg. to #120 and Duragesic to 150 mcg., without explanation for these increases.

50. On January 11, 2008, respondent wrote in his progress report that E.L. had a broken toe and that Opana was "a failure." He refilled Percocet and Duragesic at the amounts prescribed on November 15, and added #120 Actiq 400 mcg. His report does not set forth a treatment plan, and it does not explain why Opana was a failure or his rationale for prescribing Actiq. Two months later, on March 6, 2008, respondent increased Actiq to #180, 800 mcg. Respondent's report provides no explanation for this increase.

51. On April 2, 2008, respondent performed a right lumbar sympathetic nerve block, and a caudal epidural, apparently for diagnostic purposes. It is not useful to perform these procedures at the same time, as the caudal epidural blocks the same nerves as the sympathetic nerve block, preventing a differential diagnosis. Dr. Anderson testified persuasively that respondent's simultaneous performance of these two procedures demonstrated a "complete lack of understanding of the process." On May 1, 2008, respondent refilled #180 Actiq 800 mcg., #10 each Duragesic 100 mcg. and 50 mcg., and #240 Percocet 10/325.

52. Respondent's progress note for June 3, 2008, states that E.L. was using multiple pharmacies to fill her prescriptions. This is an indicator of potential abuse. There is no record in respondent's note that he discussed this issue with her.

On June 3, respondent obtained E.L.'s signature on a multi-page "Medical Treatment Contract," that set forth various items of "informed consent" and that advised E.L. of respondent's discharge policies. This is the first documentation in E.L.'s chart that informed consent was obtained for opioid treatment. With respect to opioids, the medical treatment contract states that "[t]he risk of addiction, in patients who do not have a prior addiction history (to any substance) is extremely low." The medical literature establishes that this statement is not true, as noted above in Finding 22. The Medical Treatment Contract should

have discussed the particular risks of Actiq, which include the risk of dental problems arising from continual use of the lozenges, and dependency. In addition, respondent's informed consent document is deficient in that it fails to advise the patient of medical risks associated with long-term use of opioids, as noted in Finding 22.

On June 3, respondent discontinued Percocet and added #240 Norco 10/325 mg. to E.L.'s monthly prescription. Respondent's progress report is illegible.

53. On July 25, 2008, respondent refilled E.L.'s prescriptions and increased Actiq to 1200 mcg., #180. His progress report is illegible.

54. E.L. saw respondent on September 18, 2008. He refilled her prescriptions of #120 Norco 10/325 mg., #10 each Duragesic 100 mcg. and 50 mcg., #120 Dilaudid 8 mg., and increased Actiq to 1600 mcg., #180. Respondent's progress note provides no legible explanation for increasing Actiq.

55. On October 3, 2008, respondent prescribed #120 Actiq 1600 mcg. His records do not reveal a visit by E.L. on this date, or any explanation for the prescription.

56. On October 16, 2008, E.L. reported bilateral foot and ankle pain, left knee pain, and pain in the small of her back. She had recently received a cortisone shot in the left knee from an orthopedist and felt that her condition was better. Despite E.L.'s report of improvement, respondent increased Actiq 1600 mcg. to #240, without explanation. His progress report is illegible.

57. On December 12, 2008, E.L. complained again of bilateral foot pain and left knee pain. Respondent discontinued Dilaudid, but refilled Duragesic and increased Actiq 1600 mcg. to #300. His progress report is illegible.

58. On March 30, 2009, E.L. again reported bilateral foot pain and left knee pain, and intermittent hip pain. Respondent continued Duragesic and increased Actiq 1600 mcg. to #360. This represents, in the persuasive opinion of Dr. Anderson, a "huge dose" of fentanyl that is not consistent with the drug's purpose of alleviating breakthrough pain. Respondent continued E.L. at these amounts throughout 2009. Respondent's progress report for March 30 is illegible.

59. On January 8, 2010, E.L. complained of left knee, bilateral foot and ankle pain. She told respondent her condition was better and that her pain had decreased. Respondent increased Actiq 1600 mcg. to #450 and increased Duragesic to 175 mcg., #10 each of 100 mcg. and 75 mcg. Respondent's progress report illegible for the most part, and does not explain the increase in E.L.'s medications.

60. E.L. complained of left knee and bilateral foot pain on March 5, 2010; most of her patient report is obscured due to a copying error. Respondent added #10 MSIR 20 mg to E.L.'s monthly prescriptions for "breakthrough pain."

61. Respondent's records reveal that E.L. had a neurosurgery consult on March 12, 2010. On April 6, 2010, respondent saw E.L. and obtained her signature on a second Medical Treatment Contract, and refilled her prescriptions through May 2010. This was E.L.'s last appointment with respondent.

62. As noted in Finding 10, it is the standard of care to obtain an accurate and adequate history of the patient's condition. Respondent's history of E.L. was inaccurate and inadequate, as it failed to reflect E.L.'s past diagnoses of diabetes mellitus and hypertension, and imputed to her a family history that she did not report. In Dr. Anderson's opinion, this was a simple departure from the standard of care, and his opinion is persuasive.

63. As noted in Findings 10 and 26, it is the standard of care to obtain and document a patient's informed consent to opioid treatment. Respondent failed to obtain and document informed consent from E.L. regarding treatment with opioids until June 3, 2008, after he had treated her for over 19 months. Respondent's informed consent document improperly minimized the risk of addiction, failed to advise E.L. of the medical risks associated with long-term use of opioids, and failed to inform her of the particular risks associated with the use of Actiq. In Dr. Anderson's persuasive opinion, this was an extreme departure from the standard of care.

64. As noted in Findings 10 and 27, it is the standard of care to establish a treatment plan for a chronic pain patient, with objectives by which the success of the treatment plan can be measured. Respondent failed to document a treatment plan for E.L. This was, in Dr. Anderson's persuasive opinion, an extreme departure from the standard of care for the reasons set forth in Finding 27.

65. As noted in Findings 10 and 28, it is the standard of care for a physician prescribing opioids for chronic pain to periodically review his treatment in light of new information and the patient's progress. Respondent failed to conduct periodic reviews of E.L. to assess her pain and function in response to prescribed medications, and failed to reassess the continued use of opioids in light of new information. Despite E.L.'s emergency room visit for an accidental overdose; despite respondent's discovery that E.L. was taking medications for depression, that she had a history of bipolar disorder and a history of alcohol abuse; and despite respondent's discovery that E.L. was using multiple pharmacies, respondent continued to prescribe escalating amounts of opioids. In Dr. Anderson's persuasive opinion, this was an extreme departure from the standard of care.

*Closure of respondent's practice*

66. On a date not established by the evidence, but apparently in late October or early November 2010, respondent abruptly closed his office at 310 South Halcyon, and stopped seeing patients.

67. Respondent did not notify his patients that he was going to close his office.

68. Respondent asserts, in essence, that he could not give notice to his patients because he was evicted from his office suddenly and without notice. At hearing, respondent testified that one day in late October or early November a deputy sheriff, accompanied by the property manager, came to his office and told him that he was being evicted due to unpaid rent, and that he had 24 hours to vacate the premises. Respondent testified that it was "absolutely a surprise" because he had never been served with eviction documents and, before the sheriff arrived at his office, he had no knowledge of any issues with the landlord.

Respondent's testimony is inconsistent with the statement he gave to Board representatives in his May 2011 interview. At his interview, respondent acknowledged that in October 2010 he had been having financial difficulties, that he owed his landlord – a physician whom he knew – about \$6,000 in rent, and that he had been served with eviction papers:

We -- we were having trouble with our -- with our rent and were trying to get reimbursement back for some of our tenant improvements which we never received. And so the landlord we -- went forward with the eviction process. We were served with papers, but they weren't served directly to me. They were dropped off, actually, with my staff, and so by the time those were noticed, it was actually too late.

Regarding the eviction papers, respondent went on to state,

We were -- again, they weren't brought to my attention. Papers are dropped off all day long at the office, at the front desk, so they would go in an 'in' pile. So I wasn't formally noticed that this was the documentation for legal matters and da-da-da-da. So by the time I got to it, it was a little bit little, a little bit too late.

Respondent's testimony that he could not notify his patients of his office closure because the eviction was an "absolute surprise" to him is not credible.

69. Respondent testified that, although he was told initially that he had to vacate the premises within 24 hours, he was ultimately given two weeks to move out. Respondent never sent notice to his patients that his office was closed; he did not send them notice during

that two-week period, or after. Respondent testified that the names and addresses of his patients were stored in his computer but “the servers,” which belonged to him, were “inaccessible.” He does not explain why the servers were accessible before the sheriff came to his office, but was not accessible after, nor does he explain what efforts he made, if any, to obtain his patients’ names and addresses from his computer. Insofar as respondent claims that he was unable to give notice to his patients, or that he made reasonable efforts to give notice to his patients, his claim is unpersuasive.

70. Respondent testified that, after his office closed, he made himself available to his patients by posting signs at 310 South Halcyon. Respondent’s statements on this issue have been ambiguous. In his interview in May 2011, respondent stated that the signs gave his new post office address and the number of his answering service; later in the interview, he corrected himself and said that the signs gave his cell phone number. At hearing, respondent testified that the signs had his post office box and the number of his answering service, which had his cell phone number. In any event, posting signs at 310 South Halcyon was not notice that was reasonably calculated to reach his patients, as respondent lacked control over the premises.

71. Moreover, respondent’s description of the signage is inconsistent with the observations of his patients and Board Senior Investigator Susan Thadani.

On January 8, 2011, patient Y.S. reported to the Board that she had gone to respondent’s office for a scheduled appointment on December 15, 2010. At that time, she found a sign that the office was closed for the holidays and that it would reopen on January 4, 2011, and that patients would be contacted to reschedule appointments. Also taped to the door of the office, however, was a “Demand for Rent.”

On February 21, 2011, patient W.G. informed the Board that she had gone to respondent’s office for a scheduled appointment in mid-December and found that the office was “completely shut down” and that everything was gone. She stated that she saw a real estate sign in the window and a “For Rent” sign.

In her interview with respondent in May 2011, Thadani informed respondent that she went to 310 South Halcyon on January 12, 2011, and saw a note that stated, “Sorry for the inconvenience, but the office is closed. We will call to reschedule patients as soon as we possibly can.” Respondent told Thadani “That shouldn’t have been there” and suggested that perhaps his staff had changed his original note. He acknowledged, however, that there was “one note, and only one note,” that his staff would not have had any reason to change his note, and that he had not visited the property since the day he moved out. Thadani also informed respondent that she had called his work number and heard a “nonsensical” recording that did not give a cell phone number or a post office box, to which respondent replied, “I’d have to check to see. Okay.”

Respondent’s testimony that he made himself available to his patients by posting signs that informed patients how to reach him is not credible.

72. After his office closed, respondent failed to respond to patient requests for their medical records.

In his complaint to the Board, patient P.M. states that on December 7, 2010, he sent respondent a written request for his medical records and, by January 18, 2011, he had not received a response.

On October 22, 2010, patient H.J. sent respondent a request for his medical records, addressed to respondent's office at 310 South Halcyon, and the letter was returned marked "Return to sender, unclaimed, unable to forward."

On February 2, 2011, W.G. sent respondent a written demand for her medical records. Her request, sent to respondent's office at 310 South Halcyon, was returned by the post office marked "Return to sender, unclaimed, unable to forward."

73. Respondent testified that he did not respond to the requests for records of P.M., H.J. and W.G. because he did not receive them. Respondent's testimony on this point begs the issue. The requests were properly addressed to respondent's business address. Respondent did not make arrangements to have his mail forwarded to his new post office box, or he did not pick up his mail. In either case, respondent failed to make himself available to respond to his patients' medical needs after his office closed, and failed to timely respond to their written requests for their medical records.

74. Y.S. was respondent's only patient with an implanted Medtronic pump for the administration of pain medication. In her January 8, 2011 complaint to the Board, Y.S. stated that her pump was to be refilled on November 17, 2010, but at that appointment respondent's staff informed her that they had forgot to order the refill, and asked her to return on December 15. When she returned on December 15, the office was closed. By that time, Y.S. writes, her pump had been empty for close to a month, she could not wait for her appointment to be rescheduled, and, to start with a new doctor, she needed her medical records from respondent. At some time, not established by the record, Y.S.'s pump was refilled due to the efforts of a Medtronic representative and respondent.

75. When a physician closes his practice, it is the standard of care to notify one's patients so that they can take steps to assure continuity of their care. For chronic pain patients, it is the standard of care to provide prescriptions for 30 to 60 days, to give them time to secure a new provider. Respondent demonstrated a lack of responsibility and care for his patients in that he failed to provide them with timely notice of his office closure and failed to be available to respond to their medical needs after his office closed. In Dr. Anderson's opinion, this was an extreme departure from the standard of care, and his opinion is persuasive.

76. A physician has special obligations to assure continuity of care for patients who receive medications from an implanted pump. An empty pump can cause disastrous consequences for the patient: the pump can freeze up, requiring a surgical procedure to

remove it; the patient can be thrown into severe withdrawal; and an emptying pump, without assurance of a timely refill, can create extraordinary anxiety and stress for the patient. Respondent abandoned patient Y.S. and placed her at risk of withdrawal and of complications arising from her Medtronic pump going empty. In Dr. Anderson's opinion, respondent's conduct endangered Y.S., and was an extreme departure from the standard of care. His opinion is persuasive.

77. Respondent failed to timely produce copies of patient records in response to the written requests of patients W.G., P.M. and O.H., as required by Health and Safety Code section 123110. Dr. Anderson testified persuasively that this was an extreme departure from the standard of care.

*Respondent's evidence*

78. Respondent testified that, for the past two years, he has maintained a solo chronic pain practice in Santa Barbara, where he has around 30 patients. He is vague concerning his professional activities between the time his office in Arroyo Grande closed in the fall of 2010, and the date he started his solo practice in or around 2013. Respondent testified that he continued to see some of his Arroyo Grande patients "who were able to contact me," and that he did home visits for some patients, but that there was also a time when he did not see patients at all.

79. Respondent acknowledges that this case has brought some practice deficiencies to light. He states that some people find his handwriting hard to read, but adds that his transcriptionist was able to read his writing with "99 percent" accuracy. Respondent acknowledges that he does not always "transfer [his] thought process" to the patient's chart; he would be open to taking a record keeping course.

At the conclusion of the hearing, respondent testified that he should have given notice to his patients about the closure of his practice. He continued to maintain, unpersuasively, that he could not give notice to them because he could not access their demographic information in his computer. If respondent's testimony was intended as an acknowledgment that he failed to conform to the standard of conduct, it is unconvincing and it is given little weight.

80. On the fundamental matters of his care of S.A. and E.L., respondent does not admit any deficiencies. He denies that he failed to develop a treatment plan; his treatment plan, he maintains is "inherent or implied in what I do to treat these patients." His philosophy, he states, is simple: to reduce the patient's pain scores. His treatment goals for every chronic pain patient are to reduce the patient's pain, increase the patient's function, and improve the patient's quality of life. He "disagrees completely" with the criticism that he failed to perform periodic reviews of S.A. and E.L., which he states he performed at every visit. Respondent states that it is "impossible" that the caudal epidural obliterated the ganglion block, and insists that these procedures were "absolutely a success." Respondent sees nothing wrong with the escalating doses of opioids he prescribed for S.A. and E.L.

## LEGAL CONCLUSIONS

1. The standard of proof applied in reaching the factual findings set forth above is clear and convincing evidence to a reasonable certainty.
2. The Board may take disciplinary action against a licensee who has engaged in unprofessional conduct. (Bus. & Prof. Code, § 2234.<sup>4</sup>)

### *First cause for discipline: Patient S.A.*

3. The term unprofessional conduct is defined by section 2234 to include gross negligence (subd. (b)), and incompetence (subd. (d)). The term gross negligence means “the want of even scant care or an extreme departure from the ordinary standard of conduct.” (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052-1053.) The term “incompetence” implies a lack of “qualification, ability or fitness to perform a prescribed duty or function.” (*Id.* at p. 1054.)

4. Respondent was grossly negligent when he failed to obtain and document informed consent from S.A. until October 31, 2008, after he had been treating her with opioids for over 19 months, when he advised S.A. that patients without a prior history of substance abuse have a low risk of addiction to opioids, and when he failed to inform her of the medical risks of long-term opioid treatment. (Findings 10, 22 & 26.)

5. Respondent was grossly negligent when he failed to document a treatment plan for S.A. (Findings 10 & 27.)

6. Respondent was grossly negligent when he failed to conduct periodic reviews of patient S.A. to assess her pain and function in response to prescribed medications. (Findings 10 & 28.)

7. Respondent was grossly negligent when he failed to refer S.A. for psychological evaluation. (Findings 10 & 29.)

8. Cause exists under section 2234, subdivisions (b) and (d), to take disciplinary action against respondent’s certificate.

### *Second cause for discipline: Patient E.L.*

9. Respondent was negligent when he failed to perform an adequate history and physical examination of E.L. (Findings 10, 31 & 62.)

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<sup>4</sup> All further statutory references are to the Business and Professions Code, unless otherwise stated.

10. Respondent was grossly negligent when he failed to obtain and document informed consent from E.L. until June 3, 2008, after he had been treating her with opioids for over 19 months. (Findings 10, 52 & 63.)

11. Respondent was grossly negligent when he failed to document a treatment plan. (Findings 10 & 64.)

12. Respondent was grossly negligent when he failed to conduct periodic reviews of E.L. to assess her pain and function in response to prescribed medications. (Findings 10 & 65.)

13. Respondent was incompetent on April 2, 2008, when he performed a paravertebral sympathetic ganglion block at the same time as a caudal epidural. (Finding 51.)

14. Cause exists under section 2234, subdivisions (b) and (d), to take disciplinary action against respondent's certificate.

*Third cause for discipline: Patients Y.S., W.G., P.M. and O.H.*

15. Respondent was grossly negligent when he failed to provide his patients with timely notice of his office closure, and failed to be available to meet their medical needs after his office closed. (Finding 75.)

16. Respondent was grossly negligent when he abandoned Y.S., and placed her at risk of withdrawal and of complications arising from her Medtronic pump going empty. (Finding 76.)

17. Respondent was grossly negligent when he failed to timely produce copies of patient records in response to the written requests made by patients W.G., P.M. and O.H. (Finding 77.)

18. Cause exists under section 2234, subdivisions (b) and (d), to take disciplinary action against respondent's certificate.

*Fourth cause for discipline: repeated negligent acts*

19. The term unprofessional conduct is defined to include repeated negligent acts. (§ 2234, subd. (c).) This term means two or more negligent acts. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

20. Cause exists under section 2234, subdivision (c), to take disciplinary action against respondent's certificate, by reason of the matters set forth in Legal Conclusions 4 through 7, 9 through 12, and 15 through 17.

*Fifth cause for discipline: Failure to maintain adequate and accurate records*

21. Unprofessional conduct includes the failure to maintain adequate and accurate records relating to the provision of services to patients. (§ 2266.) Respondent repeatedly failed to maintain adequate and accurate records relating to the provision of services to patients S.A. and E.L. (Findings 13 through 25, 30 through 60.) Cause exists under sections 2234 and 2266 to take disciplinary action against respondent's certificate.

*Disciplinary considerations*

22. The Board has adopted guidelines that must be considered before discipline is imposed against a physician. (Cal. Code Regs., tit. 16, §1361.) Among other things, the guidelines state proposed minimum and maximum disciplinary actions for unprofessional conduct. For each instance of gross negligence and incompetence found in this case, the minimum proposed disciplinary action is stayed revocation and five years' probation, and the maximum proposed action is outright revocation.

It is respondent's burden to demonstrate that he is sufficiently rehabilitated from his misconduct so that it would not be contrary to the public interest to allow him to continue to practice medicine. Respondent has no history of prior discipline, and there is some evidence of rehabilitation. Respondent recognizes that his handwritten progress notes are illegible for the most part, and that his charting practices could be improved.

Evidence of rehabilitation, however, must be measured against the licensee's misconduct: the more serious the misconduct, the stronger the showing of rehabilitation must be. Respondent's professional misconduct was egregious. He prescribed ever-increasing amounts of opioids to S.A., a patient with chronic pain syndrome, without properly informing her of the risks of long-term opioid treatment, without establishing objectives to measure the success of the treatment, and despite clear evidence that the opioid treatment was failing. Likewise, in the case of E.L., another patient he diagnosed with chronic pain syndrome, respondent prescribed escalating amounts of opioids without properly informing her of the risks of long-term opioid treatment, and without establishing objectives to measure whether his treatment was successful. He continued to prescribe increasing amounts of opioids to E.L. even after he learned that she was filling her prescriptions at different pharmacies, that she had overdosed on her medications, and that she had a history of substance abuse. In addition, he simultaneously performed two procedures on E.L., destroying the diagnostic value of the procedures. As to these matters, there is no meaningful evidence of rehabilitation. Respondent defends his conduct and insists that it was proper. There is no reason to believe that, confronted with similar circumstances in the future, respondent would conduct his practice differently.

And there is the matter of respondent's conduct upon the closure of his practice. When he closed his practice, respondent was indifferent to the medical needs of his patients. When he was asked to explain why he did not take the basic step of notifying his patients that his practice had closed, respondent offered explanations that are not credible. Respondent

states now that he should have notified his patients, but his testimony on this point is given little weight as he also continues to maintain, unpersuasively, that he could not notify them. Compassion for one's patients, and honesty, are required qualities of a physician. On this record, respondent's conduct does not demonstrate those qualities.

Probation is not appropriate in this case. It would be contrary to the public interest to allow respondent to retain his physician's and surgeon's certificate, even on a probationary basis.

23. All arguments advanced by respondent and not addressed in this proposed decision have been considered, found to be without merit, and rejected.

### ORDER

Physician's and Surgeon's Certificate Number A 69536, issued to respondent Andrew Gregory Monroy, M.D., is revoked.

DATED: June 1, 2015



DAVID L. BENJAMIN  
Administrative Law Judge  
Office of Administrative Hearings

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7

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

11 In the Matter of the Accusation Against:

Case No. 03-2010-207456

12 ANDREW GREGORY MONROY, M.D.  
13 P.O. Box 160  
Arroyo Grande, CA 93421

ACCUSATION

14 Physician's and Surgeon's Certificate  
15 No. A 69536

16 Respondent.

17  
18 Complainant alleges:

19 PARTIES

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

22 2. On or about August 13, 1999, the Medical Board of California issued Physician's and  
23 Surgeon's Certificate Number A 69536 to Andrew Gregory Monroy, M.D. (Respondent). The  
24 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the  
25 charges brought herein and will expire on December 31, 2012, unless renewed.

26 ///

27 ///

28

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board),<sup>1</sup> Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in pertinent part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. 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, or such other action taken in relation to discipline as the Board deems proper.

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

"The Division of Medical Quality 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 [Chapter 5, the Medical Practice Act].

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<sup>1</sup> The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)



1 subdivision (c) of the Health and Safety Code, and a Schedule II controlled substance as defined  
2 by Section 1308.12 of Title 21 of the Code of Federal Regulations. Actiq is indicated only for the  
3 management of breakthrough cancer pain in patients with malignancies who are already receiving  
4 and who are tolerant to opioid therapy for their underlying persistent cancer pain. Fentanyl is a  
5 mu-opioid agonist that can produce drug dependence of the morphine type. The concomitant use  
6 of other CNS depressants, including other opioids, sedatives or hypnotics, tranquilizers, skeletal  
7 muscle relaxants, sedating antihistamines, and alcoholic beverages may produce increased  
8 depressant effects, including hypoventilation, hypotension, and profound sedation. The initial  
9 dose of Actiq to treat episodes of breakthrough cancer pain should be 200 mcg.

10 B. **Dilaudid** is a trade name for **hydromorphone hydrochloride**. It is a dangerous drug  
11 as defined in section 4022 of the Code, a Schedule II controlled substance as defined by section  
12 11055, subdivision (d) of the Health and Safety Code, and a Schedule II controlled substance as  
13 defined by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations. Dilaudid is a  
14 hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is  
15 relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon  
16 repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered  
17 with caution. Patients receiving other narcotic analgesics, anesthetics, phenothiazines,  
18 tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system  
19 depressants, including alcohol, may exhibit an additive central nervous system depression. When  
20 such combined therapy is contemplated, the use of one or both agents should be reduced.

21 C. **Duragesic** is a trade name for a **fentanyl transdermal system**. Fentanyl is an opioid  
22 analgesic. It is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled  
23 substance as defined by section 11055, subdivision (c) of the Health and Safety Code, and a  
24 Schedule II controlled substance as defined by Section 1308.12 of Title 21 of the Code of Federal  
25 Regulations. Fentanyl's primary effects are anesthesia and sedation. Fentanyl is a strong opioid  
26 medication and is indicated only for treatment of chronic pain (such as that of malignancy) that  
27 cannot be managed by lesser means and requires continuous opioid administration. Fentanyl  
28 presents a risk of serious or life-threatening hypoventilation. When patients are receiving

1 Fentanyl, the dosage of central nervous system depressant drugs should be reduced at least 50%.  
2 Use of Fentanyl together with other central nervous system depressants, including alcohol, can  
3 result in increased risk to the patient.

4 D. **Kadian, MS Contin, and MSIR** are all trade names for **morphine**. Morphine is a  
5 dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance and  
6 narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a  
7 Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of  
8 Federal Regulations. Morphine can produce drug dependence and has a potential for being  
9 abused. Tolerance and psychological and physical dependence may develop upon repeated  
10 administration. Abrupt cessation or a sudden reduction in dose after prolonged use may result in  
11 withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must  
12 be undertaken gradually.

13 E. **Norco** is a trade name for **hydrocodone bitartrate with acetaminophen**.  
14 Hydrocodone Bitartrate is a semisynthetic narcotic analgesic. It is a dangerous drug as defined in  
15 section 4022 of the Code, a Schedule III controlled substance and narcotic as defined by section  
16 11056, subdivision (e) of the Health and Safety Code, and a Schedule III controlled substance as  
17 defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations.

18 F. **Opana** is a trade name for **oxymorphone hydrochloride**. Oxymorphone  
19 hydrochloride is a semisynthetic opioid analgesic whose principal therapeutic action is analgesia.  
20 Other therapeutic effects of oxymorphone include anxiolysis, euphoria, and feelings of relaxation.  
21 It is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance  
22 and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a  
23 Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of  
24 Federal Regulations. With pure opioid agonist analgesics, there is no defined maximum dose; the  
25 ceiling to analgesic effectiveness is imposed only by side effects, the more serious of which may  
26 included somnolence and respiratory depression.

27 G. **OxyContin** is a trade name for **oxycodone hydrochloride controlled-release tablets**.  
28 Oxycodone is a white odorless crystalline powder derived from an opium alkaloid. It is a pure

1 agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of  
2 oxycodone include anxiolysis, euphoria, and feelings of relaxation. OxyContin is a dangerous  
3 drug as defined in section 4022 of the Code, and a Schedule II controlled substance and narcotic  
4 as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II  
5 controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal  
6 Regulations. Respiratory depression is the chief hazard from all opioid agonist preparations.  
7 OxyContin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual  
8 dosage) in patients who are concurrently receiving other central nervous system depressants  
9 including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and  
10 alcohol.

11 H. **Percocet**, a trade name for a combination of **oxycodone hydrochloride and**  
12 **acetaminophen**, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar  
13 to those of morphine. It is a dangerous drug as defined in section 4022 of the Code, and a  
14 Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)(N)  
15 of the Health and Safety Code, and a Schedule II controlled substance as defined by Section  
16 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations. Percocet can produce drug  
17 dependence of the morphine type and, therefore, has the potential for being abused. Percocet  
18 contains 5 mg. of oxycodone hydrochloride and 350 mg. of acetaminophen. Repeated  
19 administration of Percocet may result in psychic and physical dependence.

20 I. **Restoril** is a trade name for **temazepam**, a hypnotic agent. Temazepam is a  
21 dangerous drug as defined in section 4022 of the Code, a Schedule IV controlled substance  
22 and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a  
23 Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of  
24 Federal Regulations. Temazepam is indicated for the short-term treatment of insomnia (generally  
25 7-10 days). Patients using temazepam should be warned about the possible combined effects with  
26 alcohol and other central nervous system depressants. As with any hypnotic, caution must be  
27 exercised in administering temazepam to individuals known to be addiction prone.

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1 J. **Soma** is a trade name for **carisoprodol** tablets. Carisoprodol is a muscle-relaxant and  
2 sedative. It is a dangerous drug as defined in section 4022 of the Code, a Schedule III controlled  
3 substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety  
4 Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the  
5 Code of Federal Regulations. Since the effects of carisoprodol and alcohol or carisoprodol and  
6 other central nervous system depressants or psychotropic drugs may be addictive, appropriate  
7 caution should be exercised with patients who take more than one of these agents simultaneously.

8 K. **Valium** is a trade name for **diazepam**, a psychotropic drug used for the management  
9 of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous  
10 drug as defined in section 4022 of the Code, a Schedule IV controlled substance as defined by  
11 section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined  
12 by Section 1308.14 of Title 21 of the Code of Federal Regulations. Diazepam can produce  
13 psychological and physical dependence and it should be prescribed with caution particularly to  
14 addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of  
15 such patients to habituation and dependence.

16 L. **Xanax** is a trade name for **alprazolam** tablets. Alprazolam is a psychotropic triazolo  
17 analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used  
18 for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety.  
19 It is a dangerous drug as defined in section 4022 of the Code, a Schedule IV controlled substance  
20 and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a  
21 Schedule IV controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of  
22 Federal Regulations. Xanax has a central nervous system depressant effect and patients should be  
23 cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during  
24 treatment with Xanax.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Incompetence re: Patient S.A.<sup>2</sup>)

10. Respondent's certificate to practice medicine is subject to disciplinary action for unprofessional conduct under section 2234, subdivisions (b) and/or (d), of the Code in that respondent was grossly negligent and/or he was incompetent in his care and treatment of patient S.A., as more particularly alleged hereinafter.

11. On or about March 5, 2007, patient S.A, a 49-year-old female, first saw Respondent upon referral from her primary care physician. The referral indicated that the patient had hemochromatosis (iron overload) and chronic hip joint pain. On the intake form completed at the first visit patient S.A. reported complaints of pain across her lower back, pelvic area, and down the right lower extremity. She reported that the pain began in 2003. She reported a pain level of 10 on a scale of 1-10. Respondent took a history and he performed a physical examination. Respondent's diagnoses were chronic pain syndrome, lumbar degenerative disc disease, and hip bursitis. Respondent recommended x-rays of the lumbar spine and right hip. He prescribed #90 Dilaudid 4 mg. and he gave the patient a recommendation for medical marijuana good for six months. X-rays of the lumbar spine and right hip were done on March 20, 2007. Impression was "unremarkable" on both x-rays. Respondent's handwritten progress notes for patient S.A. are brief, illegible, and unintelligible.

12. Patient S.A. saw Respondent approximately monthly during 2007. On June 19, 2007, S.A. continued to complain of severe and constant pain. Respondent prescribed #90 Dilaudid 8 mg. and #60 Xanax XL 1 mg. On August 7, 2007, S.A. reported a pain level of 10/10. Respondent prescribed #60 Xanax, increased Dilaudid 8 mg. to #120, and he added #30 Soma 350 mg. On December 4, 2007, S.A. reported that she was receiving chiropractic care as needed and that she was scheduled to see an orthopedic surgeon later that month. Respondent refilled #120 Dilaudid and #60 Xanax, discontinued Soma, and he prescribed #30 Valium 5 mg.

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<sup>2</sup> The patients are referred to by their initials in this document to protect their privacy. Respondent knows the identities of the patients and can confirm them through discovery.

1           13. On January 15, 2008, S.A. reported she had shingles. Respondent refilled #120  
2 Dilaudid, #60 Xanax, #30 Valium, he added #60 Kadian 30 mg. and he gave the patient five  
3 samples of Lidoderm patches.<sup>3</sup> Respondent also gave S.A. a recommendation for medical  
4 marijuana good for six months.

5           14. On April 15, 2008, Respondent saw S.A. and discontinued Kadian and Valium.  
6 Respondent refilled #120 Dilaudid 8 mg. and #60 Xanax XL 1 mg., and he added #20 Restoril 15  
7 mg. and #60 Soma 350 mg. Respondent's records indicate that S.A. was provided with  
8 prescriptions for refills of #120 Dilaudid for May and June 2008.

9           15. Respondent next saw S.A. on September 12, 2008. Medications were refilled at the  
10 amounts prescribed on April 15, 2008. On October 31, 2008, Respondent saw S.A. and refilled  
11 #120 Dilaudid 8 mg., #60 Xanax XL 1 mg., #60 Soma 350 mg., and #20 Restoril 15 mg.  
12 Respondent's records contain a "Medical Treatment Contract" signed by the patient on this date.  
13 The Medical Treatment Contract provided, in part, that "The risk of addiction [to opioid  
14 analgesics], in patients who do not have a prior addiction history (to any substance) is extremely  
15 low." This statement is medically incorrect.

16           16. Throughout 2009 Respondent continued to see patient S.A. approximately monthly  
17 and refill medications. On May 8, 2009, Respondent added #60 Valium 5 mg. to S.A.'s  
18 prescribed medications. On October 2, 2009, Respondent saw S.A. and discontinued Restoril and  
19 Valium and added #60 MS Contin 30 mg. On October 30, 2009, Respondent saw S.A. and  
20 discontinued MS Contin and prescribed #240 Dilaudid 4 mg., #60 Xanax XL 1 mg., and #60  
21 OxyContin 60 mg. Medications were refilled monthly at these amounts through March 2010.

22           17. On April 23, 2010, patient S.A. saw Respondent and requested a recommendation for  
23 medical marijuana. S.A. asked Respondent to back date the recommendation for legal reasons  
24 related to her boyfriend's recent arrest on drug charges. Respondent did not provide a  
25 recommendation for medical marijuana. He obtained a sample from S.A. for drug testing. The  
26

27           <sup>3</sup> Lidoderm is a trade name for lidocaine topical, a local anesthetic. It is used to relieve  
28 post-shingles pain.

1 drug test results were reported on or about April 27, 2010. S.A. tested negative for OxyContin  
2 and Dilaudid. Respondent discharged S.A. from his practice on or about this date.

3 18. Respondent's conduct, acts and/or omissions, with regard to patient S.A. constitute  
4 unprofessional conduct through gross negligence and/or incompetence, pursuant to section 2234,  
5 subdivision (b) and/or (d), of the Code, and is therefore subject to disciplinary action. More  
6 specifically, Respondent is guilty of unprofessional conduct with regard to patient S.A. as  
7 follows:

8 a. Respondent failed to obtain and document informed consent from patient S.A. until  
9 October 31, 2008, after he had been treating the patient for over 19 months.

10 b. Respondent failed to document a treatment plan.

11 c. Respondent failed to conduct periodic review of the patient in order to assess S.A.'s  
12 pain and function in response to prescribed medications.

13 d. Respondent failed to consider referring S.A. for psychological evaluation.

14 e. Respondent demonstrated a lack of knowledge and a lack of understanding regarding  
15 the risks of addiction to opioid analgesics.

#### 16 SECOND CAUSE FOR DISCIPLINE

17 (Unprofessional Conduct: Gross Negligence/Incompetence re: Patient E.L.)

18 19. Respondent's certificate to practice medicine is subject to disciplinary action for  
19 unprofessional conduct under section 2234, subdivisions (b) and/or (d), of the Code in that  
20 respondent was grossly negligent and/or he was incompetent in his care and treatment of patient  
21 E.L., as more particularly alleged hereinafter.

22 20. On or about October 23, 2006, patient E.L., a 52-year-old female, first saw  
23 Respondent with complaints low back pain and burning, aching pain in her feet, worse in the left  
24 foot. On the intake form E.L. completed at the first visit, she reported foot surgery in 2003; a  
25 history of diabetes mellitus, hypertension, pain and depression; and, that current medications  
26 included Percocet and Vicodin. Respondent took a history and he performed a physical  
27 examination. Respondent documented in his "Initial Evaluation" report that E.L. was "negative"  
28 for diabetes mellitus and hypertension. No details regarding E.L.'s history of foot surgery are

1 noted. Respondent's Initial Evaluation does not document any examination with regard to the  
2 possibility of peripheral neuropathy. Respondent's diagnoses were chronic pain syndrome,  
3 lumbar degenerative disc disease, and status post foot fracture. Respondent prescribed #60  
4 Kadian 20 mg. No follow up date is noted in the record. Respondent's handwritten progress  
5 notes for patient E.L. are brief, illegible, and unintelligible.

6 21. Respondent next saw patient E.L. on November 6, 2006. E.L. reported improvement  
7 in the pain in her back and hip, and continued pain in her feet, especially the left foot and ankle.  
8 The records note that E.L. was taking her medication more than prescribed. Respondent ordered  
9 x-rays of the lumbar spine and hip and he prescribed #60 Kadian 30 mg. and #120 Percocet  
10 7.5/500 mg. Three weeks later, on November 28, 2006, E.L. reported that Kadian made her  
11 sleepy. She returned the medication to Respondent. Respondent prescribed #150 Percocet.

12 22. On December 6, 2006, Respondent saw E.L. and recommended that she see her  
13 podiatrist and that she do an aquatic program. Respondent prescribed #270 Percocet. No  
14 explanation for the increase in Percocet is documented in the record.

15 23. On December 28, 2006, Respondent saw E.L. and noted that x-rays had not been  
16 done and that consultation with a podiatrist was pending. Respondent added "neuropathy" to the  
17 patient's diagnosis. Respondent refilled #180 Percocet and he gave E.L. #60 Lyrica 75 mg.<sup>4</sup>  
18 samples.

19 24. On January 5, 2007, Respondent performed bilateral lumbar 3, 4, and 5 medial branch  
20 blocks on patient E.L. On January 18, 2007, E.L. was seen in follow up and reported that her  
21 back pain was the same. She reported taking 8-9 Percocet per day. Respondent prescribed #60  
22 MS Contin 30 mg. and #90 MSIR 30 mg. for breakthrough pain.

23 25. On January 29, 2007, E.L. reported side effects from the morphine and returned the  
24 medications to Respondent. Lab tests were ordered. Respondent prescribed #10 OxyContin 40  
25 mg. On February 2, 2007, Respondent refilled #180 Percocet 7.5/500 mg.

26 ///

27 <sup>4</sup> Lyrica is a trade name for pregabalin, an anticonvulsant medication also used to treat  
28 pain caused by nerve damage in people with diabetes.

1           26. On February 14, 2007, Respondent again performed bilateral lumbar 3, 4, and 5  
2 medial branch blocks on patient E.L. The patient was seen in follow-up on March 5, 2007, and  
3 reported she was better. Respondent recommended a neurotomy<sup>5</sup> and he prescribed #180  
4 Percocet and #90 Dilaudid 4 mg. as needed.

5           27. Respondent's records document that E.L. was given a prescription on March 20,  
6 2007, for #80 Percocet. No visit is noted and no explanation is documented in the record for this  
7 prescription. On April 6, 2007, Respondent refilled #180 Percocet 10/325 mg. and #90 Dilaudid.

8           28. On May 3, 2007, E.L. reported headaches from a recent fall. Respondent performed  
9 an examination and he increased Dilaudid to 8 mg. tablets, #90, refilled #180 Percocet, and he  
10 recommended physical therapy for four weeks. On May 29, 2007, Respondent refilled #180  
11 Percocet and #90 Dilaudid, and he added #10 Duragesic 50 mcg. To the extent Respondent  
12 documented an explanation for prescribing Duragesic, his notes are unintelligible.

13           29. Respondent's records document that on June 20, 2007, a prescription for #220 Norco  
14 10/325 mg. was faxed to the pharmacy for E.L. No explanation for this prescription is noted in  
15 the record. On July 13, 2007, Norco was increased to #300 without explanation. On August 10,  
16 2007, Duragesic was increased to 75 mcg. patches, #10. Respondent added "PVD" (peripheral  
17 vascular disease) to E.L.'s diagnoses and he recommended a lumbar/diagnostic sympathetic  
18 block.

19           30. On August 22, 2007, Respondent performed a left lumbar sympathetic nerve block  
20 on patient E.L. At the follow-up visit on August 30, 2007, E.L. reported no change in her  
21 condition. Respondent prescribed #240 Percocet and he increased Duragesic to 100 mcg.  
22 patches, #10. On September 21, 2007, Respondent added #60 Opana IR 10 mg. to E.L.'s monthly  
23 prescriptions. No explanation for this additional medication is noted in the record.

24           31. On November 15, 2007, Respondent gave E.L. trigger point injections in the right  
25 lumbrosacral paraspinal area. Respondent prescribed #240 Percocet, and he increased Opana IR  
26

27  
28           <sup>5</sup> Neurotomy is the cutting of a nerve, esp. to relieve intractable pain.

1 10 mg. to #120 and Duragesic to 150 mcg. (#10 each of 100 mcg. and 50 mcg.) No explanation  
2 is noted in the record for the increases in Opana and Duragesic.

3 32. On January 11, 2008, Respondent noted that E.L. had broken a toe and that Opana  
4 was a "failure." Respondent refilled Percocet and Duragesic at the amounts prescribed on  
5 November 15, 2007, and he added #120 Actiq 400 mcg. On March 6, 2008, Respondent  
6 increased Actiq to 800 mcg., #180. No explanation is noted in the record for this increase.

7 33. On April 2, 2008, Respondent performed a right lumbar sympathetic nerve block and  
8 a caudal epidural on patient E.L. Respondent refilled #180 Actiq 800 mcg., #10 each Duragesic  
9 100 mcg. and 50 mcg., and #240 Percocet 10/325 mg. The patient was seen in follow-up on May  
10 1, 2008, and reported no change in her condition. Respondent refilled the patient's prescriptions.

11 34. Respondent's records for E.L. note on June 3, 2008, that E.L. was using multiple  
12 pharmacies to fill her prescriptions and that she was filling prescriptions early. Respondent saw  
13 E.L. on this date, but no discussion of this issue is documented in the record. X-rays of the feet  
14 and ankles were ordered. Respondent discontinued Percocet and added #240 Norco 10/325 mg.  
15 to E.L.'s monthly prescriptions. Respondent's records contain a "Medical Treatment Contract"  
16 signed by the patient on this date. X-rays were done on June 5, 2008, and revealed a Calcaneal  
17 spur and soft tissue swelling of the left foot; Calcaneal spur and mild osteoarthritis of the right  
18 foot; and, Calcaneal spur, mild degenerative changes, and nonspecific soft tissue swelling of the  
19 right ankle.

20 35. On July 25, 2008, Respondent injected Dexamethasone into E.L.'s left knee.  
21 Respondent refilled the patient's prescriptions and increased Actiq to 1200 mcg., #180. No  
22 explanation is noted in the record for this increase. On August 29, 2008, Respondent decreased  
23 Norco to #120 and he added #120 Dilaudid 8 mg.

24 36. On September 16, 2008, E.L. had an MRI done of the left knee without contrast  
25 which revealed very mild lateral subluxation patella. An x-ray of the right knee was also done on  
26 this date and revealed very mild lateral subluxation patella. X-rays of the bilateral knees – AP  
27 standing revealed "marked narrowing medial compartment of the left knee with secondary  
28

1 angulation and mild-to-moderate narrowing medial compartment of the right knee. Degenerative  
2 changes intercondylar spines bilaterally.”

3 37. On September 18, 2008, Respondent saw E.L. and refilled E.L.'s monthly  
4 prescriptions: #120 Norco 10/325 mg., #10 each Duragesic 100 mcg. and 50 mcg., #120 Dilaudid  
5 8 mg., and he increased Actiq to 1600 mcg., #180. Respondent's records document that on  
6 October 3, 2008, E.L. was given a prescription for #120 Actiq 1600 mcg. The records do not  
7 document a visit on this date nor any explanation for this prescription.

8 38. On October 16, 2008, E.L. reported that she had received a cortisone injection from  
9 an orthopedic surgeon. Respondent increased Actiq 1600 mcg. to #240. Norco may have been  
10 discontinued on this date. On December 12, 2008, Respondent discontinued Dilaudid.  
11 Respondent refilled #10 each Duragesic 100 mcg. and 50 mcg. and he increased Actiq 1600 mcg.  
12 to #300. On March 30, 2009, Respondent increased Actiq 1600 mcg. to #360. Respondent  
13 continued E.L. on Duragesic and Actiq at these amounts throughout the remainder of 2009.

14 39. On January 8, 2010, Respondent increased Actiq 1600 mcg. to #450 and he increased  
15 Duragesic to 175 mcg., #10 each of 100 mcg. and 75 mcg. No explanation is noted in the record  
16 for these medication increases. On March 5, 2010, Respondent added #10 MSIR 20 mg. to E.L.'s  
17 monthly prescriptions for breakthrough pain. Respondent's records contain a neurosurgery  
18 consultation report of March 12, 2010, indicating that E.L. had been diagnosed with a suprasellar  
19 brain tumor.

20 40. On April 6, 2010, E.L. was seen by Respondent and signed a Medical Treatment  
21 Contract similar to the one she had previously signed on June 3, 2008. Prescriptions with refills  
22 were given through May 2010.

23 41. Respondent's conduct, acts and/or omissions, with regard to patient E.L. constitute  
24 unprofessional conduct through gross negligence and/or incompetence, pursuant to section 2234,  
25 subdivision (b) and/or (d), of the Code, and is therefore subject to disciplinary action. More  
26 specifically, Respondent is guilty of unprofessional conduct with regard to patient E.L. as  
27 follows:

28 a. Respondent failed to perform an adequate history and physical examination.



1 Patient W.G.

2 44. On or about December 14, 2010, patient W.G. arrived at Respondent's office for a  
3 scheduled appointment. The office was empty and a "For Rent" sign was posted on a window.  
4 On or about February 2, 2011, patient W.G. sent respondent a certified letter requesting copies of  
5 her medical records. The letter was returned "unclaimed." On or about February 24, 2011,  
6 patient W.G. filed a complaint with the Medical Board regarding Respondent's failure to provide  
7 her with copies of her medical records.

8 Patient P.M.

9 45. On or about December 7, 2010, patient P.M. sent Respondent a certified letter  
10 requesting copies of his medical records. The records were never produced to patient P.M. On or  
11 about January 24, 2011, patient P.M. filed a complaint with the Medical Board regarding  
12 Respondent's failure to provide him with copies of his medical records.

13 Patient O.H.

14 46. On or about October 22, 2010, patient O.H. sent respondent a certified letter  
15 requesting copies of his medical records. The letter was returned "unclaimed." On or about  
16 November 30, 2010, patient O.H. filed a complaint with the Medical Board regarding  
17 Respondent's failure to provide him with copies of his medical records.

18 47. On or about May 24, 2011, Respondent was interviewed by a Medical Board  
19 Investigator and District Medical Consultant. Respondent reported that in or about late  
20 November 2010 he was evicted from his medical office. At the time of the interview, Respondent  
21 had not relocated his medical practice. Respondent reported that he continued to see  
22 approximately 10 patients in their homes. Respondent stated that he did not send a notice to his  
23 patients that his office had closed. At some point, a notice was posted on the office door advising  
24 patients that they would be contacted to reschedule their appointments. Respondent stated that  
25 his mail was being forwarded to a P.O. Box address and that he picked up his mail maybe every  
26 two weeks.

27 48. Respondent's conduct, acts and/or omissions with regard to patients Y.S., W.G.,  
28 P.M., and O.H. constitutes unprofessional conduct through gross negligence pursuant to section

1 2234, subdivision (b), of the Code, and is therefore subject to disciplinary action. More  
2 specifically, Respondent is guilty of unprofessional conduct as follows:

3 a. Respondent demonstrated a lack of responsibility and care for his patients in that he  
4 failed to provide them with timely notice of his office closure and he failed to be available to  
5 respond to their medical needs after his office closed.

6 a. Respondent abandoned patient Y.S. and placed the patient at risk of withdrawal and  
7 of complications arising from her Medtronic pump going empty.

8 b. Respondent failed to timely produce copies of patient records in response to written  
9 requests made by patients W.G., P.M., and O.H.

10 FOURTH CAUSE FOR DISCIPLINE

11 (Unprofessional Conduct: Repeated Negligent Acts)

12 49. In the alternative, Respondent is subject to disciplinary action for unprofessional  
13 conduct under section 2234, subdivision (c), for repeated negligent acts with regards to his acts  
14 and/or omissions as alleged in the First, Second, and Third Causes for Discipline which are  
15 incorporated herein by reference as if fully set forth.

16 FIFTH CAUSE FOR DISCIPLINE

17 (Failure to Maintain Adequate and Accurate Records)

18 50. Respondent's certificate to practice medicine is subject to disciplinary action for  
19 unprofessional conduct under section 2266 of the Code for failure to maintain adequate and  
20 accurate records relating to the provision of services to this patients, as alleged in the First and  
21 Second Causes for Discipline which are incorporated herein by reference as if fully set forth.

22 PRAYER

23 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
24 and that following the hearing, the Medical Board of California issue a decision:

25 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 69536,  
26 issued to Andrew Gregory Monroy, M.D.;

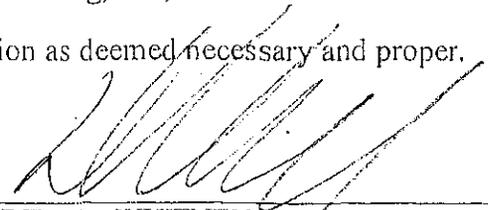
27 2. Revoking, suspending or denying approval of Andrew Gregory Monroy, M.D.'s  
28 authority to supervise physician assistants, pursuant to section 3527 of the Code;

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3. Ordering Andrew Gregory Monroy, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and,

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

DATED: May 30, 2012



LINDA K. WHITNEY  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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