

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

In the Matter of the Accusation )  
Against: )  
 )  
CLYDE M. IKUTA, M.D. )  
 )  
Physician's and Surgeon's )  
Certificate No. G 11222 )  
 )  
Respondent )  
\_\_\_\_\_ )

Case No. 8002013001739

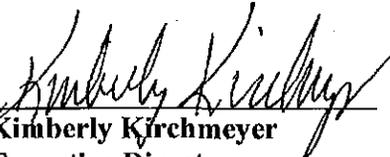
DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on January 19, 2017.

IT IS SO ORDERED January 12, 2017.

MEDICAL BOARD OF CALIFORNIA

By:   
Kimberly Kirchmeyer  
Executive Director

1 KAMALA D. HARRIS  
Attorney General of California  
2 ROBERT MCKIM BELL  
Supervising Deputy Attorney General  
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*Attorneys for Complainant*  
7

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

10 In the Matter of the Accusation Against:

11 **CLYDE IKUTA, M.D.**  
12 **601 South Beach Blvd.**  
**Anaheim, CA 92804**

13 **Physician's and Surgeon's Certificate No.**  
14 **G11222**

15 Respondent.

Case No. 800-2013-001739

OAH No. 2016090706

**STIPULATED SURRENDER OF**  
**LICENSE AND ORDER**

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

18 PARTIES

19 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board  
20 of California (Board). She brought this action solely in her official capacity and is represented in  
21 this matter by Kamala D. Harris, Attorney General of the State of California, by Colleen M.  
22 McGurrin, Deputy Attorney General.

23 2. CLYDE IKUTA, M.D. (Respondent) is represented in this proceeding by attorney  
24 Garrett S. Gregor, whose address is 26056 Acero, Mission Viejo, California 92691.

25 3. On or about September 21, 1965, the Board issued Physician's and Surgeon's  
26 Certificate No. G11222 to Respondent. Said Physician's and Surgeon's Certificate was in full  
27 force and effect at all times relevant to the charges brought in Accusation No. 800-2013-001739  
28 and will expire on October 31, 2017, unless renewed.









**Exhibit A**

**Accusation No. 800-2013-001739**

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO July 1 20 16  
BY R. Firdaus ANALYST

1 KAMALA D. HARRIS  
Attorney General of California  
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8 BEFORE THE  
9 MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

10 Case No. 800-2013-001739

11 In the Matter of the Accusation Against:

ACCUSATION

12 CLYDE IKUTA, M.D.

13 601 South Beach Boulevard  
14 Anaheim, California 92804

15 Physician's and Surgeon's Certificate G11222,  
16 Respondent.

17 Complainant alleges:

18 PARTIES

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

21 2. On September 21, 1965, the Medical Board issued Physician's and Surgeon's  
22 Certificate number G11222 to Clyde Ikuta, M.D. ("Respondent"). That license was in full force  
23 and effect at all times relevant to the charges brought herein and will expire on October 31, 2017,  
24 unless renewed.

25 JURISDICTION

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

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

- 1 "The board shall have the responsibility for the following:
- 2 "(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice
- 3 Act.
- 4 "(b) The administration and hearing of disciplinary actions.
- 5 "(c) Carrying out disciplinary actions appropriate to findings made by a panel or an
- 6 administrative law judge.
- 7 "(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
- 8 disciplinary actions.
- 9 "(e) Reviewing the quality of medical practice carried out by physician and surgeon
- 10 certificate holders under the jurisdiction of the board.
- 11 "(f) . . . (i)."

12 5. Section 2220 of the Code provides in pertinent part:

13 "Except as otherwise provided by law, the board may take action against all persons guilty

14 of violating this chapter. The board shall enforce and administer this article as to physician and

15 surgeon certificate holders . . . and the board shall have all the powers granted in this chapter for

16 these purposes including, but not limited to:

17 "(a) Investigating complaints from the public, from other licensees, from health care

18 facilities, or from a division of the board that a physician and surgeon may be guilty of

19 unprofessional conduct. The board shall investigate the circumstances underlying any report

20 received pursuant to Section 805 within 30 days to determine if an interim suspension order or

21 temporary restraining order should be issued. The board shall otherwise provide timely

22 disposition of the reports received pursuant to Section 805.

23 "(b) . . . (c)."

24 6. Section 2230.5, subdivision (a), of the Code provides that any accusation filed against

25 a licensee pursuant to Section 11503 of the Government Code shall be filed within three years

26 after the board, or a division thereof, discovers the act or omission alleged as the ground for

27 disciplinary action, or within seven years after the act or omission alleged as the ground for

28 disciplinary action occurs, whichever occurs first.

1           7.     Section 2227 of the Code states, in pertinent part:

2           “(a) A licensee whose matter has been heard by an administrative law judge of the Medical  
3     Quality Hearing Panel . . . or who has entered into a stipulation for disciplinary action with the  
4     board, may, in accordance with the provisions of this chapter:

5           “(1) Have his or her license revoked upon order of the board.

6           “(2) Have his or her right to practice suspended for a period not to exceed one year upon  
7     order of the board.

8           “(3) Be placed on probation and be required to pay the costs of probation monitoring upon  
9     order of the board.

10          “(4) Be publicly reprimanded by the board. The public reprimand may include a  
11     requirement that the licensee complete relevant educational courses approved by the board.

12          “(5) . . . .”

13          “(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical  
14     review or advisory conferences, professional competency examinations, continuing education  
15     activities, and cost reimbursement associated therewith that are agreed to with the board and  
16     successfully completed by the licensee, or other matters made confidential or privileged by  
17     existing law, is deemed public, and shall be made available to the public by the board pursuant to  
18     Section 803.1.”

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

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

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

25          “(b) Gross negligence.

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

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

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

8           “(d) Incompetence.

9           “(e) . . . (h).”

10          9. Section 2241.5 of the Code states, in pertinent part:

11           “(a) A physician and surgeon may prescribe for . . . a person under his . . . treatment for a  
12 medical condition dangerous drugs or prescription controlled substances for the treatment of pain  
13 or a condition causing pain, including, but not limited to, intractable pain.

14           “(b) No physician and surgeon shall be subject to disciplinary action for prescribing . . .  
15 dangerous drugs or prescription controlled substances in accordance with this section.

16           “(c) This section shall not affect the power of the board to take any action described in  
17 Section 2227 against a physician and surgeon who does any of the following:

18           “(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence,  
19 repeated negligent acts, or incompetence.

20           “(2) . . . .”

21           “(3) Violates Section 2242 regarding performing an appropriate prior examination and the  
22 existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

23           “(4) . . . (7).”

24           “(d) A physician and surgeon shall exercise reasonable care in determining whether a  
25 particular patient or condition, or the complexity of a patient's treatment, including, but not  
26 limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a  
27 more qualified specialist.

28           “(e) . . . .”



1 frequently he had used heroin, the amount used, the method(s) used, or any other history of illicit  
2 drug use, and the patient's use or history of alcohol consumption.

3 On this initial visit, Respondent prescribed 100 tablets of 10 milligrams (mg) of  
4 methadone;<sup>2</sup> however, he failed to perform and document an adequate and appropriate history and  
5 physical examination before prescribing opioids, which should have included an examination  
6 with documented findings, an assessment of the pain, the patient's physical and psychological  
7 function, a history of prior pain treatment(s) including any imaging, and an assessment of  
8 underlying or coexisting diseases or conditions. Respondent further failed to run a CURES report  
9 to determine if the patient was receiving pain medications from other providers and failed to  
10 require the patient to submit to a urine drug screening (UDS) to determine what drugs were in his  
11 system at the time, which were vital prior to starting opioids in a patient with a known drug  
12 addiction history. Respondent further failed to document a recognized medical indication for  
13 prescribing controlled substances, a diagnosis, or a specific treatment plan and goals.

14 When interviewed, Respondent stated that he probably performed a brief physical  
15 examination on this visit, but could not recall the specifics as he failed to document them.  
16 Respondent was also unable to decipher all of his notes from this visit.

17 15. On or about September 3, 2010, P.G. again presented to Respondent for a refill of his  
18 prescription. This chart note essentially consists of three lines only: "methadone #100 5/day;  
19 Clonidine<sup>3</sup> 0.1" with no other information. No physical examination is documented in the chart,  
20 nor is any other information documented concerning the patient's condition. Although the  
21 progress note states that 100 tablets of methadone were prescribed, the actual prescription lists  
22 only 90 tablets were prescribed. During his interview, Respondent stated that he prescribed the

23 \_\_\_\_\_  
24 <sup>2</sup> Methadone is an opioid medication used to reduce withdrawal symptoms in people addicted to heroin or  
25 other narcotic drugs without causing the "high" associated with the drug addiction. It is used as a pain reliever and as  
part of drug addiction detoxification and maintenance programs and is only available from certified pharmacies.

26 <sup>3</sup> Clonidine is a dangerous drug used to lower blood pressure by decreasing the levels of certain chemicals  
27 in ones blood which allows the blood vessels to relax and the heart to beat more slowly and easily. It is used to treat  
28 hypertension (high blood pressure) and the Kapvay brand of clonidine is used to treat attention deficit hyperactivity  
disorder (ADHD). It may also be used for other purposes.

1 clonidine to help prevent and control the patient's withdrawal symptoms, however, there is no  
2 documented evidence that the patient was suffering from any withdrawals on this visit.

3 16. On or about September 16, 2010, P.G. presented for another follow up visit with  
4 Respondent. No physical examination was documented on this visit. The patient was noted to  
5 complain of pain in his knees in the morning. Respondent refilled the prescription for 90 tablets  
6 of methadone and 60 tablets of BuSpar,<sup>4</sup> and instructed the patient to take Aleve, an over-the-  
7 counter medication, at night. During his interview, Respondent was asked if he inquired about the  
8 patient's current use of heroin on this visit. Respondent stated he did not know.

9 17. On or about September 30, 2010, P.G. was again seen by Respondent for a refill visit.  
10 On this visit, the patient was noted to have continuing complaints of pain in the feet, legs and  
11 back especially in the early morning. No physical examination was documented in the chart;  
12 however, during his interview, Respondent stated he "probably" did one, but didn't document it  
13 because he was lazy. Respondent prescribed 90 tablets of methadone, instructing the patient to  
14 take six per day, and added a new prescription for Klonopin;<sup>5</sup> however, he failed to document the  
15 reason or rationale for this. It appears that the BuSpar was discontinued on this visit; however, it  
16 is not documented in the chart.

17 Respondent's assessment was that the patient had fibromyalgia and inflammatory arthritis.  
18 This is the first time Respondent documented his diagnosis in the chart. When asked how he  
19 made his diagnosis of fibromyalgia, Respondent stated it was a "waste basket" diagnosis,  
20 although he did not know the specific criteria to make such a diagnosis, and stated that the patient

21 \_\_\_\_\_  
22 <sup>4</sup> BuSpar is the brand name for buspirone, a dangerous drug and an anti-anxiety medicine that affects  
23 chemicals in the brain that may be unbalanced in people with anxiety. It is used to treat symptoms of anxiety, such as  
24 fear, tension, irritability, dizziness, pounding heartbeat, and other physical symptoms, and may be used for other  
25 purposes.

26 <sup>5</sup> Klonopin is the brand name of Clonazepam, a Schedule IV Controlled substance in a group of drugs called  
27 benzodiazepines which affects chemicals in the brain that may become unbalanced and cause anxiety. It is also used  
28 to treat seizure disorders or panic disorder and other conditions. The patient may have thoughts about suicide while  
taking clonazepam and should call the doctor at once if the patient has any new or worsening symptoms such as:  
mood or behavior changes, depression, anxiety, or if the patient feels agitated, irritable, hostile, aggressive, restless,  
hyperactive (mentally or physically), or has thoughts about suicide or hurting oneself. The patient should not drink  
alcohol while taking the medication as the effects of the medication can increase. This medication may also be habit-  
forming.

1 had "tender points;" however, these are not documented in the chart. Respondent further stated  
2 that he would make a diagnosis of inflammatory arthritis if the patient's joint was swollen or red;  
3 however, no such information is documented in the chart.

4 18. On or about October 14, 2010, P.G. presented for a refill appointment. Respondent  
5 documented that the patient had good pain relief taking 50 mg of morphine a day and that his pain  
6 decreased from 7-8 out of 10 to a 3-4 out of 10 with the medications. This is the first time the  
7 patient's pain levels were documented. Respondent refilled the methadone and Klonopin  
8 prescriptions; however, he failed to document and perform a physical examination on this visit.  
9 Respondent requested an HIV serology and hepatitis panel, along with a syphilis test; however,  
10 this laboratory testing was never performed.

11 19. On or about October 28, 2010, P.G. presented to Respondent for a refill of his  
12 medication. This chart note essentially consists of only one entry: "methadone #110 5/day" with  
13 no other information documented other than the patient's weight and blood pressure readings. No  
14 physical examination is documented in the chart, nor is any other information concerning the  
15 patient's condition. Although the progress note states that 110 tablets of methadone were  
16 prescribed, Respondent also refilled the Klonopin prescription.

17 20. On or about November 2, 2012, five days after his prior visit, P.G. presented early for  
18 a refill of his prescription stating that his medications had been stolen. However, Respondent  
19 failed to document any other information regarding the alleged theft. Respondent further failed to  
20 perform and document a physical examination on this visit, nor any other information concerning  
21 the patient's condition. Respondent also failed to require the patient to submit to a urine drug  
22 screening (UDS) to determine the amount and what drugs were in his system at the time, to run a  
23 CURES report to determine if the patient was receiving pain medications from other providers, to  
24 document a medical indication for prescribing controlled substances, a diagnosis, or a specific  
25 treatment plan and goals. In the progress note, Respondent documented that he prescribed 45  
26 tablets of methadone and 14 tablets of Klonopin, however, the Klonopin prescription noted that  
27 only 12 tablets were prescribed.

28 21. On or about November 4, 2010, two days after last visit, P.G. presented to

1 Respondent to complete a disability form for the patient. Respondent completed and signed an  
2 Orange County "Social Services Agency General Relief Program Request for Physician's Report  
3 of Examination" indicating that the patient's diagnosis was ADHD<sup>6</sup> with the onset at birth;  
4 however, Respondent never conducted or performed any psychological testing of the patient, nor  
5 had he diagnosed the patient with this condition. Respondent stated during his interview, that he  
6 would not have performed an evaluation for this condition as he believed the patient because the  
7 patient was active in the room.

8 22. On or about November 11, 2010, P.G. presented to Respondent for a refill of his  
9 medications. This chart note essentially consists of two lines: "methadone #110; Klonopin 34"  
10 with some dosing instructions. No physical examination is documented in this chart, nor does it  
11 contain any other information concerning the patient's condition, or the alleged theft of his  
12 medications at the end of October.

13 23. On or about December 2, 2010, P.G. again presented to Respondent for a refill of his  
14 medications. No physical examination is documented in this chart, nor does it contain any other  
15 information concerning the patient's condition. Respondent refilled the medications for  
16 methadone and Klonopin; however, he added a prescription for Effexor XR,<sup>7</sup> however, he failed  
17 to document the reason or rationale for prescribing this medication. During his interview,  
18 Respondent stated that he prescribed this medication because he had diagnosed the patient with  
19 depression based upon his past history, however, there is no documentation in the chart that the  
20 patient suffered from depression or was diagnosed with this condition. Respondent further stated  
21 that the patient was not suicidal at that time, was oriented times three, and was not crying.  
22 however, none of this information is documented in the chart.

23 24. On or about December 22, 2010, January 11, 2011 and February 2, 2011, P.G.

24 <sup>6</sup> ADHD is the abbreviation for attention deficit hyperactivity disorder; a disorder characterized by a  
25 persistent pattern of inattention and/or hyperactivity.

26 <sup>7</sup> Effexor XR is the brand name for the generic drug Venlafaxine, a dangerous drug, which is an anti-  
27 depressant in a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs).  
28 Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression and is used to treat  
major depressive disorder, anxiety, and panic disorder.

1 presented to Respondent for refills of his medications. On these visits, Respondent refilled the  
2 prescriptions without change. Each of the chart entries for these visits are extremely brief and do  
3 not document a physical examination, nor any other information concerning the patient's  
4 condition.

5 25. On or about February 18, 2011, P.G. again presented to Respondent for a refill of his  
6 medications. On this visit, Respondent completed another Orange County disability form for the  
7 patient for a 5-month period. No physical examination was documented on this visit, nor any  
8 other information concerning the patient's condition; however, Respondent refilled the  
9 prescriptions for methadone, Effexor and Klonopin. Respondent also diagnosed the patient with  
10 ADHD; however, no mental examination or any other examination was documented in the chart.  
11 During his interview, Respondent stated that the patient was not suicidal and he had no plans to  
12 refer the patient to another provider; however, this information is not documented in the chart.

13 26. On or about March 24, 2011, P.G. again presented to Respondent for the refill of his  
14 medication. No physical examination was documented on this visit, or any other information  
15 concerning the patient's condition. Respondent stated during his interview, that he was trying to  
16 decrease the daily dosage of methadone from 50 mg to 45 mg, however, on this visit Respondent  
17 actually increased the methadone from 110 tablets to 145. Respondent, however, failed to  
18 document the reason or rationale for the increase. Respondent was unable to recall if the patient  
19 was depressed on this visit as he failed to document this information and failed to document his  
20 assessment of the patient's conditions and treatment plan.

21 27. On or about March 31, 2011, one week after his last visit, P.G. presented to  
22 Respondent claiming that he had lost his medications; however, Respondent failed to document  
23 the medication loss or any further information. Respondent refused to refill the medications and  
24 instructed the patient to return in three weeks; however, Respondent failed to perform and  
25 document a physical examination of the patient, to perform a UDS to determine the levels of  
26 drugs in the patient's system on this visit, to discharge the patient for presenting early for a refill  
27 of his medications and stating that his medications had either been lost or stolen for the second  
28 time, to require the patient to sign a pain management contract, to run a CURES report to

1 determine if the patient was receiving narcotics from other providers, to document his assessment  
2 and plan for the patient's care and treatment, and to document a discussion with the patient about  
3 his early refills and alleged stolen and lost medications.

4 28. On or about April 13, 2011, P.G. again presented to Respondent for a refill of his  
5 medications. On this visit, Respondent failed to document a physical examination or any  
6 additional information concerning the patient's condition. Respondent stated during his interview  
7 that the patient continued to have pain in his feet and back, but he was unsure if the patient  
8 continued to have fibromyalgia or depression. Respondent failed to document a history, physical  
9 examination, assessment or treatment plan in the patient's chart; however, he refilled the  
10 prescriptions for 140 tablets of methadone and 34 tablets of Klonopin.

11 29. On or about May 10, 2011, P.G. again presented to Respondent for the refill of his  
12 medications. No physical examination is documented on this visit, nor was it documented if the  
13 patient was still depressed or suffering from fibromyalgia. Respondent stated during his  
14 interview that he did not perform a psychiatric or neurological evaluation on this visit and did not  
15 know if he performed a physical exam. In fact, no physical examination findings were ever  
16 documented in the patient's chart including the initial visit ten months earlier. Respondent refilled  
17 the prescriptions for methadone and Klonopin.

18 30. On or about May 12, 2011, two days after his last visit to Respondent, P.G. was found  
19 dead of a drug overdose. Out of the 140 methadone tablets the patient filled on May 10, 2011,  
20 only 64 tablets were left. P.G.'s death was ruled an accidental overdose.

21 31. Throughout his care and treatment of P.G., Respondent failed to perform adequate  
22 physical examinations to require the patient submit to a UDS to determine the type and amount of  
23 drugs in his system, to run a CURES report to determine if the patient was obtaining medications  
24 from other providers, to order any laboratory studies or imaging, or to consider referring the  
25 patient for physical therapy or other alternative treatments.

26 32. Respondent committed acts of gross negligence in his care and treatment of patient  
27 P.G. when he:

28 A. Failed to perform and document an adequate and appropriate history and physical

1 examination prior to initially prescribing controlled substances;

2 B. Failed to perform and document an adequate and appropriate history and physical  
3 examinations prior to refilling the controlled substances;

4 C. Failed to discuss and document a conversation with the patient concerning the major  
5 potential risks of controlled substances;

6 D. Failed to run a CURES report and have the patient submit to urine drug screening  
7 (UDS) prior to prescribing controlled substances, especially since the patient had a history of  
8 heroin use;

9 E. Failed to document a treatment plan and management goals;

10 F. Failed to prescribe or attempt physical therapy or other conservative treatments prior  
11 to prescribing controlled substances;

12 G. Failed to appropriately evaluate and monitor the patient through his course of care  
13 and treatment;

14 H. Failed to refer the patient to a pain management specialist or other professional; and

15 I. Failed to maintain adequate and accurate records.

16 **SECOND CAUSE FOR DISCIPLINE**

17 (Repeated Negligent Acts – Patient P.G.)

18 33. Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2234,  
19 subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient  
20 P.G. The circumstances are as follows:

21 34. Paragraphs 14 through 31, and 32 A through I, inclusive, are incorporated by  
22 reference as if fully set forth herein.

23 **THIRD CAUSE FOR DISCIPLINE**

24 (Gross Negligence – Patient A.F.)

25 Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2234,  
26 subdivision (b), in that he committed gross negligence in his care and treatment of patient A.F.  
27 The circumstances are as follows:  
28

1           35. On or about September 4, 2007, patient A.F., then a 32 year old male, first presented  
2 to Respondent who noted the patient had been addicted to heroin since he was 15 years old.  
3 Respondent examined A.F. and prescribed 140 tablets of methadone. Thereafter, Respondent  
4 treated the patient through June 2009.

5           36. On or about July 2, 2009, A.F. presented for refill of his medications. On this visit,  
6 Respondent failed to document a physical examination; however he refilled the prescriptions for  
7 164 tablets of methadone and 14 tablets of Klonopin.

8           37. On or about July 16, 2009, A.F. again presented for refill of his medications. On this  
9 visit the patient's blood pressure was noted to be 160/70; however, Respondent failed to perform  
10 and document a physical examination on this visit and failed to address the patient's blood  
11 pressure readings. Respondent prescribed 160 tablets of methadone and refilled the Klonopin.

12           38. On or about July 31, 2009, the patient again presented for a refill of his medications.  
13 On this visit, Respondent failed to perform and document a physical examination; however, he  
14 prescribed 168 tablets of methadone and refilled the Klonopin.

15           39. On or about August 18, 2009, A.F. again presented for refill of his medications.  
16 Respondent again failed to perform and document the physical examination on this; however, he  
17 prescribed 162 tablets of methadone and refilled the Klonopin.

18           40. On or about September 4, 2009, A.F. again presented for refill of his medications  
19 which Respondent refilled; however, Respondent failed to perform and document a physical  
20 examination on this visit.

21           41. On or about June 22, 2010, A.F. again presented to Respondent for refill of his  
22 medications. The patient had last been seen in September 2009; however, Respondent failed to  
23 document any reason or explanation why the patient had not been seen in eight months. On this  
24 visit, Respondent again failed to perform and document a physical examination of the patient;  
25 however, he prescribed 162 tablets of methadone and added a prescription for clonidine, but  
26 failed to document the reason or rationale for prescribing the clonidine.

27           42. On or about July 2, 2010, A.F. again presented to Respondent for a refill of his  
28 medications. On this visit, Respondent noted that the patient had finally decreased his dose of

1 methadone. Respondent performed a minimal physical examination on this visit; however, he  
2 failed to document a history and his assessment and plan. Respondent prescribed 154 tablets of  
3 methadone; however, he failed to document his reason or rationale for decreasing the methadone  
4 dosage.

5 43. On or about July 13, and July 28, 2010, A.F. presented to Respondent who refilled his  
6 medications.

7 44. On or about August 30, 2010, A.F. again presented to Respondent for a refill of his  
8 medications. Respondent prescribed 140 tablets of methadone and 60 tablets of clonidine;  
9 however, he failed to document a history of the patient's condition on this visit, failed to perform  
10 and document a physical examination, and failed to document his assessment and plan.

11 45. On or about September 16, 2010, A.F. saw Respondent again for a refill of his  
12 medications. On this visit, Respondent noted that the patient had decreased his dose of  
13 methadone and was still able to work. Respondent filled the prescription for methadone,  
14 however, he failed to document a history of the patient's condition on this visit and failed to  
15 perform and document a physical examination, his assessment and plan.

16 46. On or about October 11, October 26, November 8, and November 18, 2010, A.F.  
17 again presented to Respondent for a refill of his medications. On each of these visits, Respondent  
18 failed to perform a physical examination of the patient, to document a history of the patient's  
19 condition, or to document an assessment or plan. In fact, on each of these visits, essentially the  
20 only information contained in these progress notes, other than the patient's weight and blood  
21 pressure, is the word "methadone" and the number of tablets prescribed.

22 47. On or about December 9, 2010, A.F. saw Respondent again for a medication refill.  
23 Respondent continued the methadone prescription and noted that the patient should "try clonidine  
24 to decrease methadone" even though Respondent had first prescribed clonidine on June 22, 2010.  
25 During his interview, Respondent was not sure the exact reason why he prescribed clonidine and  
26 failed to document his reasoning. On this visit, Respondent further failed to document a history  
27 of the patient's condition, and failed to perform and document a physical examination, his  
28 assessment and plan.

1           48. On or about December 15, 2010, A.F. again presented to Respondent for a refill of his  
2 medications. Respondent prescribed 140 tablets of methadone and 60 tablets of clonidine;  
3 however, he failed to document a history of the patient's condition and failed to perform and  
4 document a physical examination, his assessment and plan.

5           49. On or about January 7, 2011, A.F. presented to Respondent for a refill of his  
6 medications. Respondent refilled the methadone; however, he failed to document a history of the  
7 patient's condition on this visit, and failed to perform and document a physical examination, his  
8 assessment and plan.

9           50. On or about January 27, 2011, A.F. again presented to Respondent for a refill of his  
10 medications and Respondent prescribed another 140 tablets of methadone and 60 tablets of  
11 clonidine; however, he failed to document a history of the patient's condition, and failed to  
12 perform and document a physical examination, his assessment and plan on this visit.

13           51. On or about February 15, 2011, A.F. saw Respondent again for a refill of his  
14 medications which Respondent refilled another 140 tablets of methadone, however, he failed to  
15 document a history of the patient's condition on this visit and failed to perform and document a  
16 physical examination, his assessment and plan.

17           52. On or about March 9, 2011, A.F. saw Respondent for a refill of his medications. On  
18 this visit, Respondent noted that the patient's pain was worse due to a work injury however, he  
19 failed to document any specifics regarding the injury. Respondent performed and documented a  
20 brief physical examination although the specifics of the examination are lacking in detail. This is  
21 the first physical examination documented by Respondent since July 2, 2010. Respondent refilled  
22 the prescription for methadone; however, he failed to document his assessment and plan.

23           53. On or about March 21, April 4, May 2, May 12, and June 6, 2011, A.F. saw  
24 Respondent for a refill of his methadone. On these visits, Respondent refilled the prescriptions of  
25 methadone; however, he failed to document a history of the patient's condition on these visits and  
26 failed to perform and document a physical examination, an assessment or his plan. In fact, on  
27 each of these visits, essentially the only information contained in these progress notes, other than  
28 the patient's weight and blood pressure, is the word "methadone" and the number of tablets

1 prescribed.

2 54. On or about June 13, 2011, A.F. presented to Respondent for a refill of his  
3 medications. On this visit, the patient claimed his medications were either lost or stolen,  
4 however, Respondent failed to document the circumstances of the medication loss. Respondent  
5 refilled the prescription of methadone, however, he failed: to require the patient to submit to a  
6 UDS to determine the type and amount of drugs in his system at the time; to run a CURES report  
7 to determine if the patient was obtaining medications from other providers; to document a history  
8 of the patient's condition on this visit; and to perform and document a physical examination, his  
9 assessment or plan.

10 55. On or about October 19, 2011, and January 30, 2012, A.F. again presented to  
11 Respondent for a refill of his methadone. On these visits, Respondent refilled the prescriptions of  
12 methadone, however, he failed to document a history of the patient's condition on these visits and  
13 failed to perform and document a physical examination, an assessment or his plan. In fact, on  
14 each of these visits, the only information contained in the progress notes, other than the patient's  
15 weight and blood pressure, is the word "methadone" and the number of tablets prescribed.

16 56. On or about February 10, 2012, A.F. saw Respondent again for a refill of his  
17 methadone. On this visit, Respondent requested that the patient decrease his methadone to nine  
18 pills per day. During his interview, Respondent stated that he did not consider sending the patient  
19 for physical therapy, ordering an MRI to determine the cause of his condition, or referring to  
20 patient to another provider. Respondent refilled the prescription for methadone, however, he  
21 failed to document a history of the patient's condition and failed to perform and document a  
22 physical examination and his assessment of the patient's condition.

23 57. On or about February 17, and March 2, 2012, A.F. again presented to Respondent for  
24 a refill of his methadone. On these visits, Respondent refilled the prescriptions for methadone,  
25 however, he failed to document a history of the patient's condition on these visits and failed to  
26 perform and document a physical examination, his assessment or plan. In fact, on each of these  
27 visits, the only information contained in these progress notes, other than the patient's weight and  
28 blood pressure, are the words "methadone" or "meth" and the number of tablets prescribed.

1           58. On or about March 9, April 2, April 20, and May 2, 2012, A.F. again presented to  
2 Respondent for a refill of his methadone which was refilled. Respondent however failed to  
3 document a history of the patient's condition on these visits and failed to perform and document a  
4 physical examination, his assessment or plan. In fact, on each of these visits, essentially the only  
5 information contained in these progress notes, other than the patient's weight and blood pressure,  
6 and the words "methadone" or "meth" and the number of tablets prescribed.

7           59. On or about May 16, 2012, A.F. again presented to Respondent for a refill of his  
8 methadone. On this visit, Respondent performed and documented a physical examination noting  
9 pain in the lumbosacral area and point tenderness on the right side. This is the first documented  
10 physical examination since Respondent's brief examination of the patient on March 9, 2011.  
11 Respondent refilled the prescription of methadone; however, he failed to document his  
12 assessment and plan. During his interview, Respondent stated he did not consider alternative  
13 medications or treatments for the patient on this visit.

14           60. On or about May 31, June 11, June 26, and July 9, 2012, A.F. again presented to  
15 Respondent for a refill of his methadone, which was refilled. On each of these visits, Respondent  
16 failed to document a history of the patient's condition, and failed to perform and document a  
17 physical examination along with his assessment and plan.

18           61. On or about August 8, 2012, A.F. again presented to Respondent for a refill of his  
19 methadone, which was filled. On this visit, Respondent again failed to document a history of the  
20 patient's condition, and failed to perform and document a physical examination and his  
21 assessment and plan. The only notation in the chart, other than the patient's weight and blood  
22 pressure, is "M - 140" and that the patient was unable to come in regularly in July because he  
23 was out of town. This appears to be the patient's last visit with Respondent.

24           62. Throughout his care and treatment of A.F., Respondent failed to: perform and  
25 document an adequate physical examination; require the patient to submit to a UDS to determine  
26 the type and amount of drugs in this system; run a CURES report to determine if the patient was  
27 obtaining medications from other providers; order any laboratory studies or imaging; and  
28 consider referring the patient for physical therapy or other alternative treatments.



1 **FIFTH CAUSE FOR DISCIPLINE**

2 (Gross Negligence – Patient C.T.)

3 66. Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2234,  
4 subdivision (b), in that he committed gross negligence in his care and treatment of patient C.T.  
5 The circumstances are as follows:

6 67. On or about April 14, 2011, patient C.T., a then 41 year old male, first presented to  
7 Respondent for treatment for an opiate addiction. The patient reportedly started using heroin  
8 when he was approximately 20 to 21 years old, and was using 1 to 2 grams per day. During his  
9 interview, Respondent stated he performed a physical examination of the patient on this visit;  
10 however he failed to document his findings in the chart. Additionally, Respondent did not  
11 remember, and failed to document, whether he asked the patient when he had last used heroin  
12 and failed to document, if he asked the patient if he was, or had been, using other illicit drugs at  
13 the time.

14 On this visit, Respondent failed to document: a history of the patient's medical condition;  
15 his physical examination findings; his diagnoses, assessment and plan; failed to require the  
16 patient to submit to a urine drug screening (UDS) to ascertain the type and amount of drugs in his  
17 system at that time; and failed to have the patient the patient sign a pain management agreement.  
18 During his interview, Respondent stated that the treatment goals were "in [his] head" but failed to  
19 document them in the chart. Respondent prescribed 112 tablets of methadone and 60 tablets of  
20 clonidine.

21 68. On or about April 25, 2011, C.T. presented early for a refill of his medications. On  
22 this visit, Respondent noted that the patient complained of chronic lumbosacral pain especially  
23 with an increase in his work. Respondent refilled the prescription for methadone, but failed to  
24 perform and document a physical examination on this visit, and failed to document his assessment  
25 and plan.

26 69. On or about May 9, May 19, June 15, July 15, August 12, and August 30, 2011, C.T.  
27 presented to Respondent for a refill of his medications. On these visits, Respondent refilled the  
28 patient's prescriptions, however, he failed to: document a history of the patient's condition on

1 these visits; and failed to perform and document a physical examination nor his assessment or  
2 plan. In fact, on each of these visits, the only information contained in these progress notes, other  
3 than the patient's weight and blood pressure, are the words "methadone" or "clonidine" and the  
4 number of tablets prescribed.

5 70. On or about September 15, 2011, C.T. again presented for a refill of his methadone.  
6 On this visit, Respondent increased the prescription from 126 tablets to 130 tablets of methadone;  
7 however, he failed to document the reason or rationale for the increase. During his interview,  
8 when asked why he increased the methadone prescription, Respondent stated it was probably  
9 because the patient asked for a little more medication. Respondent, however failed to document a  
10 history of the patient's condition on this visit, failed to perform and document a physical  
11 examination, failed to chart his assessment and plan, and failed to inquire if the patient was using  
12 illicit drugs.

13 71. On or about October 5, 2011, C.T. again presented for a refill of his methadone. On  
14 this visit Respondent noted the patient complained of lumbosacral pain and restless leg syndrome,  
15 a condition he had never complained of before, however, Respondent failed to document and was  
16 uncertain about the patient's specific symptoms or the reasons why he had this new condition.  
17 Respondent also documented that the patient had been injured in a military training accident in  
18 2008, and he was now complaining of sciatica, another new condition, however, Respondent  
19 failed to ask if the patient had recently injured himself. Although Respondent failed to document  
20 a physical examination on this visit, he stated during his interview that he performed an  
21 examination but did not document it "Because I'm lazy."

22 On this visit, Respondent drafted a letter "To whom it may concern" stating C.T. was his  
23 patient and that his methadone use is "due to lumber spine pain and restless leg syndrome."  
24 Respondent, however, was not sure what the letter was for, who it was intended for, nor the  
25 reasons he wrote the letter in the first place.

26 72. On or about October 18, 2011, the patient again presented for a refill of his  
27 methadone. On this visit, Respondent increased the methadone from 100 tablets to 126 tablets,  
28 but failed to document the reason or rationale for the increase. On this progress note, Respondent

1 made a notation concerning the patient's condition although that notation was scratched out;  
2 however Respondent was unable to explain why this occurred during his interview. On this visit,  
3 Respondent failed to document a history of the patient's condition, failed to perform and  
4 document a physical examination, his assessment and plan, and failed to inquire about the  
5 patient's illicit drug use, if any.

6 73. On or about November 9, 2011, C.T. again presented for a refill of his methadone  
7 which Respondent refilled. On this visit, Respondent noted that the patient complained of an ear  
8 ache and prescribed Keflex.<sup>8</sup> During his interview, Respondent stated that he did not recall if it  
9 was both ears or just one ear, and that he "probably examined" the patient's ear, but failed to  
10 document.

11 74. On or about November 21, 2011, C.T. again presented to Respondent for a refill of  
12 his methadone and prescribed 126 tablets of methadone. No physical examination was  
13 documented on this visit and there is no indication of the status of the patient's ear ache, restless  
14 leg syndrome or sciatica noted in the prior visits.

15 75. On or about December 6, 2011, C.T. again presented to Respondent for a refill of his  
16 methadone. On this visit, Respondent prescribed 140 tablets of methadone and some Keflex;  
17 however, he failed to document the reason or rationale for the increase in the methadone nor for  
18 the Keflex. During his interview, Respondent stated that he probably prescribed the Keflex for  
19 the patient's ear, but he failed to document anything in the chart concerning the condition of the  
20 patient's ear on this visit. Further, Respondent failed to: perform and document a physical  
21 examination on this date; document a history of the patient's condition; chart his assessment and  
22 plan; and failed to inquire and document if the patient was using illicit drugs.

23 76. On or about December 27, 2011, C.T. again presented to Respondent for a refill of his  
24 methadone. On this visit, Respondent refilled the prescription for methadone, and prescribed

25 \_\_\_\_\_  
26 <sup>8</sup> Keflex is the brand name of the generic medication called cephalexin which is a cephalosporin antibiotic.  
27 It works by fighting bacteria in ones body and is used to treat infections caused by bacteria, including upper  
28 respiratory infections, ear infections, skin infections, and urinary tract infections.

1 amoxicillin<sup>9</sup> for the patient's "teeth." During his interview, Respondent was asked if he  
2 examined the patient's mouth prior to prescribing the amoxicillin. Respondent stated that he must  
3 have looked in the patient's oral cavity, however, in his deposition testimony, in a civil action  
4 filed by the patient, Respondent stated "No, I'm not a dentist" and if the patient had something he  
5 complained about "I took him for his word." On this visit, Respondent failed to document a  
6 history of the patient's condition; failed to perform and document a physical examination, failed  
7 to chart his assessment and plan, and failed to inquire and document if the patient was using illicit  
8 drugs.

9 77. On or about January 16, 2012, C.T. again presented to Respondent for a refill of his  
10 methadone and prescribed 126 tablets, however, Respondent failed to document the reason or  
11 rationale for the decrease in the methadone. On this visit, Respondent failed to: document a  
12 history of the patient's condition; perform and document a physical examination; chart his  
13 assessment and plan; and inquire and document if the patient was using illicit drugs.

14 78. On or about February 3, 2012, C.T. again presented to Respondent for a refill of his  
15 methadone which was refilled, however, no additional information was documented on this visit  
16 other than the patient's weight and blood pressure and the entry "tonic water and calcium for  
17 restless leg syndrome." Respondent, however, failed to: document a history of the patient's  
18 condition on this visit, including whether he was still suffering from sciatica or an ear ache;  
19 perform and document a physical examination; chart his assessment and plan; and inquire and  
20 document if the patient was using illicit drugs.

21 79. On or about February 21, 2012, C.T. again presented to Respondent for a refill of his  
22 methadone which was refilled. On this visit, Respondent noted that the patient complained of  
23 lumbosacral pain after running an obstacle course in 2005. This is inconsistent with the patient's  
24 prior statement in October 2011, that his injury was caused by a 2008 military training accident.  
25 When asked if these were two separate injuries, Respondent stated he believed these were both

26 <sup>9</sup> Amoxicillin is a penicillin antibiotic that fights bacteria and is used to treat many different types of  
27 infection caused by bacteria, such as tonsillitis, bronchitis, pneumonia, gonorrhea, and infections of the ear, nose,  
28 throat, skin, or urinary tract.

1 the same injuries, but he was not clear about the exact dates and failed to clarify this with the  
2 patient. Respondent further stated that he "probably" performed a brief exam on this visit,  
3 however, he failed to document his findings of the physical examination, failed to chart his  
4 assessment and plan, failed to require the patient to submit to a UDS to determine the amount and  
5 type of drugs in his system at that time, and failed to inquire and document if the patient was  
6 using illicit drugs.

7 80. On or about March 12, 2012, C.T. again presented to Respondent for a refill of his  
8 methadone which was refilled. On this visit, no additional information is documented in the chart  
9 other than the patient's weight and blood pressure and the notation of "Prednisone 10 mg #30."  
10 During his interview, Respondent stated that he prescribed Prednisone to help with the patient's  
11 pain, however, Respondent failed to document a history of the patient's current condition or why  
12 he was having an increase in his pain. Respondent further failed to perform and document a  
13 physical examination, failed to chart his assessment and plan, and failed to inquire and document  
14 if the patient was using illicit drugs.

15 81. On or about March 30, 2012, C.T. again presented to Respondent for a refill of his  
16 methadone and stated he had pulled a muscle on the left side of his back two weeks ago and still  
17 has pain, however, Respondent failed to inquire about and document the circumstances of the  
18 injury. Respondent refilled the prescriptions for methadone and prednisone and noted this would  
19 be the "last time" he would prescribe prednisone. When asked if he performed a physical  
20 examination on this visit, Respondent stated he "probably" did, but failed to document it.  
21 Respondent further failed to document his assessment and plan, and failed to inquire if the patient  
22 was using illicit drugs.

23 82. On or about April 16, 2012, C.T. again presented to Respondent for a refill of his  
24 methadone which was refilled. On this visit, the patient stated he still had back pain and tried  
25 ibuprofen, however, no other information is documented other than the patient's weight and blood  
26 pressure and the notation that he refilled the methadone prescription. Respondent failed to  
27 document a history of the patient's condition on this visit and any other information concerning  
28 his condition, failed to perform and document a physical examination, failed to chart his

1 assessment and plan, and failed to inquire and document if the patient was using illicit drugs.

2 83. On or about April 26, 2012, C.T. presented to the emergency room at St. Jude  
3 Medical Center complaining of severe upper back pain, with a severity 8 out of 10, for the last six  
4 weeks. The patient stated he was lifting a family member when he first injured his back and that  
5 the pain was worse with movement. He was administered pain medications which improved his  
6 condition, was diagnosed with acute upper back pain, and was discharged home with some  
7 muscle relaxants and was instructed to follow up with his primary care physician.

8 84. On or about May 16, 2012, C.T. again presented to Respondent for a refill of his  
9 methadone complaining of severe back pain and that he went to the emergency room two weeks  
10 ago and was diagnosed with muscle spasms, however, there is no additional information  
11 documented in the chart as to the reasons for the patient's severe back pain. Respondent noted  
12 that the patient complained of low back pain with muscle spasms, however, he failed to document  
13 any further information concerning the patient's condition on this visit. Respondent refilled the  
14 prescription for methadone and added a new prescription for Soma,<sup>10</sup> however, he failed to  
15 document a history of the patient's recent injury, failed to perform and document a physical  
16 examination, failed to chart his assessment and plan, and failed to inquire and document if the  
17 patient was using illicit drugs.

18 85. That night, on or about May 16, 2012, C.T. again presented to the emergency room at  
19 St. Jude's Medical Center for a flare up of his mid-back and was noted to have mid thoracic  
20 paraspinal tenderness and spasms upon examination. C.T. was diagnosed with back spasm and  
21 strain, and was given some Toradol<sup>11</sup> and Soma.

22 \_\_\_\_\_  
23 <sup>10</sup> Soma is a Schedule IV Controlled Substance, and is the brand name for the generic drug combination of  
24 aspirin and carisoprodol. Aspirin a pain reliever and fever reducer, in a group of drugs called salicylates, which  
25 works by reducing substances in the body that cause pain and inflammation. Carisoprodol is a muscle relaxant which  
works by blocking nerve impulses (or pain sensations) that are sent to the brain. Soma is used short-term to treat  
painful muscular conditions.

26 <sup>11</sup> Toradol is the brand name of the dangerous generic drug ketorolac, a nonsteroidal anti-inflammatory drug  
27 (NSAID) which works by reducing hormones that cause inflammation and pain in the body. Toradol is used short-  
28 term (5 days or less) to treat moderate to severe pain.

1           86. On or about May 17, 2012, one day after his prior visit, C.T. presented to Respondent  
2 for a consult according to the chart. On this visit, the patient requested a prescription for  
3 Klonopin and Clonidine; however no other pertinent information is documented in the chart for  
4 this visit. Respondent wrote prescriptions for 14 tablets of Klonopin and 60 tablets of Clonidine,  
5 along with a prescription for methadone which he had neglected to write the day before. When  
6 asked why he prescribed the Klonopin, Respondent stated it was to help the patient sleep,  
7 however, there is no information regarding the patient's sleep documented in the chart. When  
8 asked if he was aware of the patient's visit to the emergency room the night before, Respondent  
9 stated he was not.

10           87. On or about May 26, 2012, C.T. again presented to the emergency room at St. Jude's  
11 Medical Center for constant muscle spasms in his chest, upper back and neck, with a severity of  
12 10 out of 10. C.T. related that his pain was due to a previous motor vehicle accident. C.T. was  
13 diagnosed with diffuse chest and back muscle spasms and cellulitis<sup>12</sup> on the right distal leg. He  
14 was discharged with some additional medications and was told to be rechecked in about twenty-  
15 four hours.

16           88. On or about May 29, 2012, C.T. presented to Respondent for a refill of his  
17 medications which Respondent refilled, however, he increased the number of Klonopin from 14  
18 tablets to 21 tablets, but failed to document the reason or rationale. No other information is  
19 documented in the chart on this visit other than the patient's weight and blood pressure. There is  
20 no reference to the patient's emergency room visits of May 16, nor May 26. When asked if he  
21 knew the patient had been to the emergency room twice within two weeks, Respondent stated he  
22 did not. On this visit, Respondent failed to document a history of the patient's condition, failed to  
23 perform and document a physical examination, failed to chart his assessment and plan, and failed  
24 to inquire and document if the patient was using illicit drugs.

25           89. On or about June 8, 2012, C.T. again presented to Respondent for a refill of his  
26 medications. On this visit, the patient was noted to have severe low back pain for two weeks and  
27

28           <sup>12</sup> Cellulitis is a spreading bacterial infection just below the skin surface.

1 edema in the legs as well as a burning pain in his chest. Respondent noted that the patient had  
2 been to St. Jude's emergency room and was given antibiotics for cellulitis in his legs; however,  
3 no additional information is documented concerning the emergency room visit. Respondent  
4 refilled the prescriptions for methadone and Klonopin, however, Respondent failed to order any  
5 labs or diagnostic tests, failed to perform and document a physical examination, failed to chart his  
6 assessment and plan, and failed to inquire if the patient was using illicit drugs. Respondent stated  
7 during his interview that the patient was using a walker on this visit, however, he failed to  
8 document this information in the patient's chart, and Respondent failed to ascertain the reason for  
9 the increase in the patient's complaints. This apparently was the last time Respondent saw the  
10 patient.

11 90. On or about July 6, 2012, C.T. presented to the emergency room at Coast Plaza  
12 Hospital with acute paralysis of his bilateral extremities. The chart noted that the patient had no  
13 sensation from the waist down and that he had been having back pain for the last two to three  
14 months. According to the chart entries, C.T. reported that he had a history of IV heroin abuse in  
15 the past, and a history of intermittent drug use since stopping heroin ten years earlier. A urine  
16 drug screening was performed which was positive for amphetamines and other substances. C.T.  
17 was admitted to the hospital where he underwent a thoracic laminectomy<sup>13</sup> at T4 to T6 with  
18 evacuation and debridement of an epidural abscess resulting in paraplegia.

19 91. Respondent was grossly negligent in his care and treatment of patient C.T. when he:

20 A. Failed to perform and document an adequate and appropriate history and physical  
21 examination prior to initially prescribing controlled substances;

22 B. Failed to perform and document an adequate and appropriate history and physical  
23 examinations prior to refilling the controlled substances;

24 C. Failed to discuss and document a conversation with the patient concerning the major  
25 potential risks of controlled substances;

26 D. Failed to run a CURES report and have the patient submit to urine drug screening

27 <sup>13</sup> A laminectomy is a surgical operation to remove the back of one or more vertebrae (the lamina), usually  
28 to give access to the spinal cord or to relieve pressure on the nerves by enlarging the spinal canal.

1 (UDS) prior to prescribing controlled substances, especially since the patient had a history of  
2 heroin use;

3 E. Failed to document a treatment plan and management goals;

4 F. Failed to prescribe or attempt physical therapy or other conservative treatments prior  
5 to prescribing controlled substances;

6 G. Failed to appropriately evaluate and monitor the patient through his course of care  
7 and treatment;

8 H. Failed to refer the patient to a pain management specialist or other professional;

9 I. Failed to adequately evaluate and diagnose the patient's worsening and new  
10 symptoms; and

11 J. Failed to maintain adequate and accurate records.

12 **SIXTH CAUSE FOR DISCIPLINE**

13 **(Repeated Negligent Acts – Patient C.T.)**

14 92. Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2234,  
15 subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient  
16 C.T. The circumstances are as follows:

17 93. Paragraphs 67 through 90, and 91 A through J, inclusive, are incorporated by  
18 reference as if fully set forth herein.

19 **SEVENTH CAUSE FOR DISCIPLINE**

20 **(Prescribing Controlled Substances without Prior Examination – All Patients)**

21 94. Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2242,  
22 subdivision (a), in that he prescribed dangerous drugs without an appropriate prior examination  
23 and medical indication. The circumstances are as follows:

24 95. Paragraphs 14 through 31, 36 through 62, and 67 through 90, inclusive, are  
25 incorporated by reference as if fully set forth herein.

26 ///

27 ///

28 ///

1 EIGHTH CAUSE FOR DISCIPLINE

2 (Failure to Maintain Adequate and Accurate Records – All Patients)

3 96. Respondent Clyde Ikuta, M.D. is subject to disciplinary action under section 2266 in  
4 that he failed to maintain adequate and accurate records in his care and treatment of patients P.G.,  
5 A.F. and C.T. The circumstances are as follows:

6 97. Paragraphs 14 through 31, 36 through 62, and 67 through 90, inclusive, are  
7 incorporated by reference as if fully set forth herein.

8 FACTORS IN AGGRAVATION

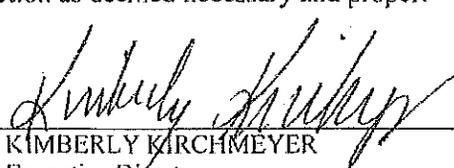
9 98. Not as independent grounds for disciplinary action, but as a matter in aggravation  
10 should discipline be imposed, it is alleged that in a prior decision of the Board on May 19, 1998,  
11 the Respondent was publically reprimanded in connection with Medical Board of California case  
12 number 04-1995-047158.

13 PRAAYER

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

- 16 1. Revoking or suspending Physician's and Surgeon's Certificate Number G11222,  
17 issued to Clyde Ikuta, M.D.;
- 18 2. Revoking, suspending or denying approval of his authority to supervise physician  
19 assistants, pursuant to section 3527 of the Code;
- 20 3. Ordering Clyde Ikuta, M.D., if placed on probation, to pay the Board the costs of  
21 probation monitoring; and
- 22 4. Taking such other and further action as deemed necessary and proper.

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24 DATED: July 1, 2016

  
KIMBERLY KIRCHMEYER  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant

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