

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

In the Matter of the First)
Amended Accusation and Petition)
to Revoke Probation Against:)

JOHN F. PETRAGLIA, M.D)

Case No. 04-2013-229649

Physician's and Surgeon's)
Certificate No. G 68169)

Respondent)
_____)

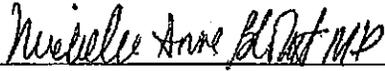
DECISION AND ORDER

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 September 20, 2017.

IT IS SO ORDERED: August 21, 2017.

MEDICAL BOARD OF CALIFORNIA



Michelle Anne Bholat, M.D., Chair,
Panel B

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OAH No. 2015040494

PROPOSED DECISION

Administrative Law Judge Ralph B. Dash heard this matter in Los Angeles, California on June 20, 21, 22, 23, and 24, December 14, 15, 16, 19, 20 21, 22, and 23, 2016 and March 21, 22 and 23, and April 21, 2017.

Deputy Attorney General Rebecca L. Smith represented Kimberly Kirchmeyer (Complainant), the Executive Director of the Medical Board of California (Board).

Attorney at Law Joel B. Douglas represented John F. Petraglia, M.D. (Respondent).

The record remained open until June 19, 2017, for receipt of closing and reply briefs. Complainant's closing and reply briefs were timely received and were marked for identification as Exhibits 131 and 132, respectively. Respondent's closing and reply briefs were timely received and were marked for identification as Exhibits A-R and A-S, respectively. The record was closed on June 19, 2017.

Oral and documentary evidence having been received and the matter having been submitted, the Administrative Law Judge makes the following Proposed Decision.

FACTUAL FINDINGS

1. Complainant made the First Amended Accusation and Petition to Revoke Probation in her official capacity.

2. On March 12, 1990, the Board issued Physician's and Surgeon's Certificate Number G 68169 to Respondent. The license was in effect at all times relevant to the charges brought herein, but subject to the prior disciplinary order described below, and is due to expire March 31, 2018.¹

3. In a disciplinary action entitled *In the Matter of the Second Amended Accusation against John F. Petraglia, M.D.*, Board case number 04-2011-219449 (the underlying action), the Board issued a Decision on August 22, 2013, effective September 20, 2013, in which Respondent's Physician's and Surgeon's Certificate was revoked based on allegations of gross negligence and repeated negligent acts in the care and treatment of five patients, as well as Respondent's failure to maintain adequate records. However, the revocation was stayed and Respondent was placed on seven years of probation, together with a partial restriction on prescribing controlled substances, and the requirement to complete a prescribing practices course, a medical record keeping course, an ethics course, a clinical training program, and other standard terms and conditions. In the stipulation resolving the disciplinary matter, Respondent specifically admitted only that he failed to maintain adequate and accurate records on five patients in the underlying action. However, under the terms of the stipulated settlement, Respondent agreed that should the Board file a petition to revoke probation, "all of the charges and allegations contained in Accusation No. 04-20110219499 [the underlying action] shall be deemed true, correct and fully admitted by Respondent"

4. In this proceeding, Complainant seeks revocation of Respondent's certificate based on his care and treatment of four patients who were seen and treated by Respondent during the same time period as the original five patients involved in the underlying action. No explanation was offered as to why the underlying action did not involve all nine patients. The alleged failures by Respondent in his care and treatment of these four patients are of the same nature, and no more serious, as his now-admitted failures with respect to the original five patients, and his record keeping failures are virtually identical. By way of example, and not by way of limitation, the following is a brief excerpt of the now admitted allegations from the Second Amended Accusation in the underlying action. The allegations are included to demonstrate that Respondent's competence in dealing with complex pain patients remained at a consistently substandard level during the period Respondent treated all nine patients. However, that does not mean that his license should be disciplined to a greater extent by the mere inclusion of four additional patients whom Respondent treated in the same manner. Respondent successfully completed the prescribing course, the record keeping course and the clinical training program. Those courses appear to have had their intended effect. There are no allegations that Respondent has failed to properly treat any patients since he completed those courses. The exemplar allegations from the underlying action are as follows, and should be compared with Findings 5 through 15 below.

¹ While Respondent had been a board-certified anesthesiologist, with a subspecialty in pain management, his probationary status makes him ineligible to maintain those certifications.

"17. On or about March 3, 2009 Respondent saw L.Z. -Respondent wrote the following note in his record for that visit:

""[L.Z.] also states he is [sic] used OxyContin in the past, obtained from the street as well as through prescription medications. Although he denies of[sic] using this medication, he appears overly concerned with his pain and seeking medication of this type to relieve it."

"Respondent's records failed to include any discussion of alternative treatments. The medication section of the note stated, "OxyContin (80 milligrams when needed) Adderall." Although the associated patient questionnaire, dated March 4, 2009, indicates that L.Z. was also taking Wellbutrin, there is no reference to this drug in Respondent's note. The physical exam section of the note is essentially identical to that contained within the February 23, 2009 note, except for minor additions (e.g., 'The sensory examination is within normal limits with the exception of bilateral hand [sic] numbness' [which is added in the cervical spine section]). The plan for this visit includes a recommendation for "modified OxyContin prescription," and notes that "patient states he was previously taking 80 mg but no specific prescribing physician can be identified." On or about March 4, 2009, Respondent prescribed OxyContin 60 mg, quantity 90, with instructions to take one three times daily. He also prescribed Soma to the patient. However, the consultation report indicated that Respondent intended to prescribe Zanaflex rather than Soma for treatment of muscle spasm. Respondent's documentation for this visit also does not provide sufficient explanation for his increasing the dosage of OxyContin from 80 mg daily to 180 mg daily, notwithstanding that L.Z.'s pain intensity had not changed. His pain intensity was 6 out of 10 on or about February 23, 2009, and March 3, 2009.

"18. On or about March 16, 2009 Respondent saw L.Z. again. The record for this visit is only a brief handwritten note. His plan included injections and recommendations MRI scans. Respondent prescribed OxyContin 80 mg (90 pills), with instruction to take one three times daily. He also prescribed Soma 350 mg (120 pills) and Cymbalta 24 60 mg, to be taken twice daily. Respondent's documentation for this visit also does not provide sufficient explanation for his increasing the dosage of OxyContin dosage from 180 mg to 240 mg daily or why he changed the strength of the Soma formulation (i.e., it was increased from 250 mg to 350 mg). Respondent also failed to discuss the inconsistent urine drug screen result collected on or about February 23, 2009, and available on or about March 16, 2009, in which L.Z. tested positive for benzodiazepine yet had not reported taking a benzodiazepine. There is also a consultation report, dated March 17, 2009, relating to the brother of L.Z., misfiled in L.Z.'s medical records.

"19. On or about April 9, 2009, Respondent saw L.Z. again. This record is a handwritten note. Respondent failed to address the urine drug screen results at this visit. Respondent refilled the prescriptions for OxyContin and Soma at this time and also added a new prescription for Vicodin 5/500 (120 pills), which he explained in his interview with the Medical Board was for treatment of breakthrough pain. There is no explanation in the note regarding why the patient needed the additional prescription for Vicodin. On or about April 9, 2009, L.Z. also provided urine for a drug screen.

“20. There is a patient questionnaire, Patient Information Update, dated April 16, 2009, but there is no accompanying physician note in the record to verify that a visit occurred on this date.

“21. On or about April 27, 2009, Respondent saw L.Z. Respondent noted that L.Z.'s physical therapy and massage had been helpful, and that he had been using OxyContin on a regular basis and doing well with this regimen. Respondent also reviewed the results of the urine test from the initial visit in February 2009, and noted the inconsistent results. He said, ‘Although his urine initially was in noncompliance, there is no reason to suspect that he is not taking the OxyContin prescribed to him at this time.’ Respondent indicated that while the lumbar MRI was completed, the cervical MRI had not been done ‘due to patient non-compliance in scheduling.’ Respondent reiterated the same physical examination findings as in his earlier typed reports. In his assessment section, he added the diagnosis of ‘opioid dependence syndrome.’ Respondent recommended that the patient see ‘a support counselor or psychologist’ for his attention deficit disorder, and undergo regular urine testing. Although Respondent also recommended a CURES report; there is no evidence that he obtained a CURES report at this point. The April 27, 2009, chart note also indicated that Respondent would refill L.Z.'s prescription for OxyContin and naproxen, but there is no evidence in Respondent’s medical records (i.e., a copy of the prescription or a notation in the medication log) that this was done at that time. However, the CVS Pharmacy records indicate three prescriptions that Respondent issued on that date to L.Z., including OxyContin 80 mg (30 pills), Norco 10/325 mg (160 pills), and Soma 350 mg (90 pills). However, there was no prescription for naproxen, which is another inconsistency in the documentation.”

The four patients at issue in the current pleading²

5. Patient T.S.

a. T.S. was a 23-year-old female patient who died on December 20, 2011. The cause of death was an overdose from the combined effects of oxycodone, oxymorphone, and alprazolam. T.S. was first seen by Respondent on February 28, 2011, for mid back pain, low back pain, bilateral hand numbness, tingling, and leg pain. She reported no history of substance or alcohol abuse in the patient questionnaire.

b. T.S. was diagnosed with carpal tunnel syndrome, thoracic myofascial pain, lumbar radiculopathy with a likely exacerbation of a lumbar disc injury, lumbar facet syndrome, cervical neuralgia, obesity, and a sleep disorder. Respondent's treatment recommendations included a lumbar MRI, consideration of a lumbar epidural steroid,

² Because no additional disciplinary action is being imposed as a result of Respondent’s care and treatment of the four patients, a detailed discussion of the expert testimony presented by each side has been omitted. It should be noted that the Findings that follow were established by clear and convincing evidence elicited from two experts on behalf of Complainant. Respondent’s expert testimony did not rebut that of Complainant’s experts.

exercises, physical therapy, chiropractic care, and the continuation of prescriptions given by a prior treating physician of hydrocodone and alprazolam.

c. Respondent's actual care of T.S. included inter alia a lumbar epidural steroid injection and hydrocodone, which was later switched to oxycodone. Refills of medications prescribed by Respondent occurred approximately every 21 days during T.S.'s treatment.

d. Three urine screens reflected in T.S.'s medical records were all sent to Calloway Laboratory for analysis. The first urine screen in the records was done on October 17, 2011. There were multiple inconsistencies in the reported urine results including a negative result for alprazolam, which was prescribed to T.S. by Respondent on September 27, 2011. In addition, the urine results showed a positive opioid level. Although oxycodone is a synthetic opioid, it does not usually trigger a positive opioid result on a lab test unless the patient is taking high doses. The urine results also showed positive for tramadol which was not prescribed to T.S. by anyone. Lastly, the report shows that the oxymorphone level was nearly three times higher than the oxycodone level, which indicates that higher than prescribed doses were being taken, which Respondent should have taken note of.

e. The second urine screen was done on November 2, 2011. Respondent again noted that the patient's medications listed in the urine screen report were wrong, but failed to address that issue. Respondent noted that the report erroneously listed that the patient was taking Norco and failed to list that the patient was taking alprazolam. Additional inconsistencies in this report are a positive hydromorphone level which was not being prescribed and cannot be explained by opioid metabolism. The high level of oxymorphone compared to oxycodone, as was shown on the initial report, was again reflected in the second report and reflects a higher dose than that being prescribed. Respondent failed to address these issues with T.S.

f. The third urine screen occurred on November 29, 2011, and again showed a very high oxymorphone level.

g. Respondent negligently failed to comply with the standard of care for prescribing controlled substances to T.S. by failing to follow the standard of care for prescribing controlled substances for chronic pain conditions. The standard of care in the community requires:

i. A medical history and physical exam, including an assessment of the patient's pain, including physical and psychological status and function;

ii. The patient's substance abuse history;

iii. A history of prior treatments and an assessment of any other underlying or co-existing conditions; and

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iv. Documentation of recognized medical indications for the use of controlled substances such as opiates for pain control.

h. Respondent failed to get a full substance abuse history and failed to justify the need for controlled substances. T.S. indicated on her intake questionnaire that she had no substance abuse history, but no further inquiry was made by Respondent over the course of treatment despite the urine test result inconsistencies.

i. Respondent failed to establish medical indications for the use of opioids that are clear through the history, physical exam, or MRI findings.

j. Respondent's treatment plan and objectives did not meet the standard of practice requirements that the medical records contain stated objectives. All of Respondent's follow-up reports are hand-written on preprinted forms and circled words on the form do not indicate positive or negative findings. Furthermore, when findings were not circled it cannot be determined if those findings were negative or were not tested. Lastly, some of the hand-written reports are signed by both M.S., D.C., and Respondent, and it cannot be determined which provider was documenting findings and making recommendations.

k. Respondent failed to discuss the risks and benefits of the use of controlled substances along with other treatment modalities with T.S. The record does not contain an opioid agreement and there is no indication that the risks, benefits and alternatives to controlled substances were discussed with the patient.

l. Respondent failed to periodically review the course of pain treatment for T.S. and failed to make appropriate modifications in T.S.'s treatment based on T.S.'s progress or lack of progress. Respondent failed to review information pertaining to use of controlled substances, including CURES reports, on a periodic basis.

m. Respondent obtained three urine screens that showed significant discrepancies but Respondent failed to identify the discrepancies and failed to address those discrepancies. The records show that T.S. was receiving opioids from two clinics, had positive urine screens with substances not prescribed by Respondent, and had claimed to have lost prescriptions requiring an early refill. All of the facts indicate drug-seeking behavior by the patient and a need for Respondent to evaluate a substance abuse disorder, which Respondent failed to identify.

n. Respondent failed to obtain additional evaluations and consultations from other physicians, as required, when dealing with complex medical pain problems. Although Respondent consulted with T.S.'s prior treating physician, they both continued to provide controlled substances to T.S.

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6. Patient J.C.

a. J.C. was a 52-year-old female patient who died on July 22, 2012. The cause of death was an overdose from the combined effects of morphine, methamphetamine, amphetamine, alprazolam, hydroxyalprazolam, diazepam, nordiazepam, oxazepam and temazepam.

b. J.C. first consulted with Respondent on October 26, 2011, with complaints of neck, arm, back and knee pain. Her past medical history showed a prior cervical fusion and surgery on the left humerus, which resulted in a non-union. She also had cervical stenosis, an unspecified birth defect, depression, and she smoked. At the time of her initial consultation, J.C. was using Xanax, Valium, Norco, Soma, and another medication unclear from the records.

c. Respondent gave J.C. multiple cervical, shoulder, and neck injections on four separate occasions without any documented benefit.

d. J.C.'s medical records reflect three CURES reports, dated October 26, 2011, December 28, 2011, and June 11, 2012, received by Respondent. A comparison of the medical records with the CURES reports show that J.C. did not fill prescriptions for Soma and morphine. In addition, the clinical notes from J.C.'s consultations with Respondent on April 12, 2012, May 1, 2012, and July 16, 2012, are confusing as to whether Cymbalta and/or Pristiq, or both were prescribed. Respondent testified that he had samples of each medicine that he would give patients when indicated, but he was not clear as to whether he gave this patient one or both of these medicines.

e. Respondent failed to document any inquiry into J.C.'s substance abuse history, failed to require a urine report before prescribing controlled substances for J.C., and then gave prescriptions for multiple sedatives including two benzodiazepines, Soma, and increased her opioid prescriptions. Respondent failed to document the need for both Valium and Xanax prescriptions. There is no mention in the medical records if those substances helped J.C. in the past or if there were side effects, and no stated objective for their use was given.

g. Respondent's treatment plan and objectives did not meet the Board's guideline requirements that the medical records contain stated objectives. All of Respondent's follow-up reports are hand-written on preprinted forms and circled words on the form do not indicate positive or negative findings. Furthermore, when findings are not circled it cannot be determined if those findings were negative or were not tested. Lastly, on November 21, 2011, Respondent changed J.C.'s prescription from 30 mg of hydrocodone per day to 120 mg of morphine per day, a significant increase. On the next visit on December 28, 2011, J.C. reported falling. However, Respondent did not discuss this incident's possible relation to her medical regimen.

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h. Respondent failed to discuss the risks and benefits of the use of controlled substances along with other treatment modalities with J.C. The record does not contain an opioid agreement and there is no indication that the risks, benefits and alternatives to controlled substances were discussed with J.C.

i. Respondent was negligent in that he failed to adequately review the course of pain treatment for the patient and failed to make appropriate modifications in J.C.'s treatment based on J.C.'s progress or lack of progress. J.C. reported a history of depression and was referred to the clinic's psychologist, but no record of a meeting is found. The degree of depression was not commented on. The reason why two benzodiazepines were required was not documented.

7. Patient K.D.

a. On December 12, 2007, K.D., a then 42-year-old woman, first presented to Respondent's office for a pain management evaluation. At that time, Respondent made a diagnosis of status post motor vehicle accident with persistent increase in lower back pain, status post anterior cervical discectomy and fusion at C4-5-6 with probable dislodgement disruption of hardware after collision. Respondent recommended that K.D. have a cervical CAT scan and consider lumbar epidural steroid injection for diagnostic purposes. He also considered cervical facet injections and continuing K.D.'s oral medications of Soma, one to four tablets a day, and Norco, 10 mg, one to six tablets a day. He started K.D. on a trial of Lyrica and performed a right trigger point, sacroiliac joint injection.

b. On January 10, 2008, K.D. presented to Respondent at Alliance Surgery Center for injection therapy. Respondent performed the following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3) epidural lysis of adhesions and injection of epidural steroid; and (4) epidurogram, fluoroscopy with evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-evaluation and further recommendations. It was noted that a second epidural was recommended if necessary and if pain and dysfunction persisted, Respondent would proceed to discogram study and potential lumbar plasma-mediated disc decompression with the recommendation of interventional pain management care on an appropriate and evidence based method. K.D. was instructed to undergo possible re-injection as needed, consider discogram study with disc decompression and physical therapy for current exacerbation of symptoms twice a week for two weeks upon authorization from her worker's compensation provider.

c. On January 10, 2008, Respondent made changes to K.D.'s opioid medication regimen without documenting his reasons for doing so.

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d. On January 29, 2008, K.D. presented to Respondent at either Alliance Surgical Center or Orangewood Surgical Center for injection therapy.³ Respondent performed the following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3) epidural lysis of adhesions and injection of epidural steroid; and (4) epidurogram, fluoroscopy with evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-evaluation and further recommendations. It was noted that if pain and dysfunction persisted, Respondent would proceed to discogram study and lumbar plasma-mediated disc decompression with the recommendation of interventional pain management care on an appropriate and evidence based method. K.D. was instructed to undergo possible re-injection as needed, consider discogram study with disc decompression and physical therapy for current exacerbation of symptoms twice a week for two weeks upon authorization from her worker's compensation provider.

e. On February 12, 2008, K.D. presented to Respondent at Orangewood Surgical Center for injection therapy. Respondent performed the following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3) epidural lysis of adhesions and injection of epidural steroid; (4) injection of flank myofascial trigger points; and (5) epidurogram, fluoroscopy with evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-evaluation and further recommendations. It was noted that if pain and dysfunction persisted, Respondent would proceed to discogram study and lumbar plasma-mediated disc decompression with the recommendation of interventional pain management care on an appropriate and evidence based method. K.D. was instructed to undergo possible re-injection as needed, consider discogram study with disc decompression and physical therapy for current exacerbation of symptoms twice a week for two weeks upon authorization from her worker's compensation provider.

f. On March 10, 2008, K.D. was seen by Respondent at his office at which time he performed a pain management evaluation and adjusted her opioid medications.

g. On March 18, 2008, K.D. presented to Respondent at either Orangewood Surgical Center or Alliance Surgical Center for injection therapy.⁴ Respondent performed

³ K.D.'s certified medical records from Orangewood Surgical Center documents the January 28, 2008 procedures on Alliance Surgical Center letterhead as well as Orangewood Surgical Center letterhead. K.D.'s certified medical records from Respondent's office has the January 28, 2008 procedures documented on Alliance Surgical Center letterhead.

⁴ K.D.'s certified medical records from Orangewood Surgical Center document the March 18, 2008 procedures on Orangewood Surgical Center letterhead. K.D.'s certified medical records from Respondent's office document the March 18, 2008 procedures on Alliance Surgical Center letterhead.

the following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve roots L3, L4, L5 and S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3) epidural lysis of adhesions/injection of epidural steroid; (4) epidurogram and fluoroscopy with evaluation of radiographs; and (5) injection of trigger points of right flank and hip. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-evaluation and further recommendations. She was instructed to undergo possible re-injection as needed, consider discogram study with disc decompression and physical therapy for current exacerbation of symptoms twice a week for two weeks upon authorization from her worker's compensation provider.

h. On May 6, 2008, K.D. presented to Respondent at Orangewood Surgical Center for injection therapy. Respondent performed the following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural procedure with fluoroscopy; (3) injection of epidural steroid; and (4) epidurogram, fluoroscopy with evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-evaluation and further recommendations. She was instructed to undergo physical therapy twice a week for two weeks for current exacerbation of symptoms upon authorization from her worker's compensation provider; undergo additional epidural if necessary and possible re-injection; and consider discogram study with disc decompression if pain and dysfunction persisted.

i. On November 19, 2008, K.D. was seen by Respondent for a pain management evaluation and at that time, he refilled her opioid medications.

j. On December 2, 2008, K.D. presented to Respondent at Orangewood Surgical Center for injection therapy. At that time, Respondent performed the following procedures:

(1) bilateral lumbar L3, L4 and L5 facet injections with medial branch nerve block with arthrography; (2) bilateral sacroiliac joint injections with arthrography; (3) and fluoroscopy with evaluation of radiographs. Following the procedures, K.D. was instructed to call Respondent's office for re-evaluation and further recommendations. She was also instructed to continue stretching as instructed; undergo physical therapy for current exacerbation of symptoms; and facet and/or repeat epidural injection as needed. Respondent also noted that further recommendations would follow based upon K.D.'s response to therapy.

k. On January 16, 2009, K.D. was seen by Respondent for pain and opioid medication management.

l. On February 24, 2009, K.D. presented to Respondent at Orangewood Surgical Center for injection therapy. Respondent performed the following procedures: (1) bilateral lumbar facet injections at L3-4, L4-5, L5-S1 with medial branch nerve block with arthrogram study; (2) bilateral sacroiliac joint injections with arthrogram study; and (3) fluoroscopy with

evaluation of hard copy of radiographs. Following the procedures, K.D. was instructed to call Respondent's office for a follow up consultation, re-evaluation and further recommendations. Respondent recommended physical therapy for current exacerbation of symptoms upon authorization from her worker's compensation provider twice a week for two weeks; second epidural if necessary with possible re-injection; discogram study with disc decompression procedure for presumed discogenic pain syndrome; and follow up appointment with neurosurgical/orthopedic consult, Dr. B.C.

m. On March 4, 2009, May 11, 2009, June 10, 2009, August 7, 2009, and February 11, 2010, and K.D. was seen by Respondent for evaluation and opioid medication management.

n. On February 23, 2010, K.D. presented to Respondent at Orangewood Surgical Center for injection therapy. Respondent noted that K.D. has had multiple surgical interventions to attempt to cure her condition without full relief of her symptom complex. Respondent performed the following procedures: (1) a lumbar epidural multilevel catheterization of disc levels L3-4, L4-5, L5-S1; (2) a lumbar epidural multi-level selective neuroplasty injection of nerve roots L3, L4, L5 and S1; (3) epidurograph and evaluation of radiographs; (4) bilateral lumbar facet injections at L3-4, L4-5, L5-S1 and medial branch nerve block; and (5) right lumbar transforaminal selective nerve root steroid injection block at the right L5 level. Respondent recommended additional epidural and facet block as medically necessary.

o. K.D. continued to treat with Respondent for pain management evaluation and opioid medication management and was last seen by Respondent on May 17, 2011.

p. Respondent failed to comply with the standard of care for performing epidural injections on K.D., as follows:

i. The standard of care requires that a physician obtain and review spinal imaging prior to performing epidural injections in order to come to a definitive diagnosis and more precisely target the source of pain prior to performing the procedure.

ii. The standard of care requires physicians to limit the total number of steroid injections per year to minimize the systemic side effects of steroid administration.

iii. The standard of care requires that a physician assess the clinical effectiveness of spinal procedures before repeating them.

q. Respondent failed to obtain or review spinal imaging prior to performing epidural injections on K.D.

r. Respondent administered steroid injections to K.D. in excess. From December 2007 through December 2008, Respondent administered steroid injections a total of 10 times.

Further, on several occasions, he administered multiple doses of steroids on the same day to different anatomic locations.

s. Respondent arbitrarily performed a series of epidural injections without interval assessment of treatment efficacy. There is no documentation of interval patient assessment of K.D. between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

t. Respondent recorded treatment plans at each of K.D.'s visit, but failed to describe the objectives of treatment over the course of treating K.D. Further, Respondent's medical records for K.D. are nearly illegible and fail to document standard guidelines in the use of controlled substances for patients with chronic pain conditions.

8. Patient R.J.

a. Patient R.J., a then 24-year-old male, first presented to Respondent on August 26, 2009, for an evaluation of lower back pain, left elbow pain, and headaches. Respondent noted that the patient had a history of multiple injuries and had been maintained on medications by different pain management physicians in the past. Respondent noted that the patient wanted to lower his medication intake and was open to chiropractic care, low intensity laser therapy and other alternative options. Respondent performed a physical examination. Respondent's impressions were lumbar disc injury, mechanical back pain with facet arthrosis, lumbar muscle spasm with myofascial pain syndrome, sleep disorder, mild depression, history of cigarette smoking, history of left fifth finger tendon hood derangement, history of right elbow fracture, olecranon bursitis, cervical spasm, and history of attention deficit disorder. Respondent recommended diagnostic testing with lumbar MRI and elbow x-rays. R.J. signed an opioid therapy consent form, a treatment agreement for use of opioid medications and a generic procedure consent form.

b. At the time of the initial consultation on August 26, 2009, Respondent prescribed OxyContin 40 mg, quantity 60, with instructions to take one tablet twice daily, Xanax 2mg, quantity 60, with instruction to take one every four to six hours as needed for pain. Respondent did not obtain a urine drug screen or a CURES report when he first examined the patient.

c. Respondent saw the patient for thirteen additional visits from September 9, 2009, through August 16, 2011. Aside from the first consultation on August 26, 2009, Respondent's progress notes were on pre-printed templates using a checkbox format with illegible handwritten comments, some of which were difficult even for Respondent to read when he was asked about them during his Medical Board interview.

d. R.J. presented to Respondent on September 9, 2009, with complaints of low back pain with his pain intensity being seven on a scale of one to 10. Respondent recommended physical therapy and a lumbar epidural injection in addition to refilling the patient's medications. Respondent prescribed OxyContin 40 mg, quantity 60, Xanax two mg,

quantity 60, and Percocet 10mg/325 mg, quantity 120. While the prescription is dated September 9, 2009, the medication log reflects that the medications were prescribed on September 8, 2009. The record is absent an explanation as to why these medications were refilled only two weeks after the August 26, 2009 prescriptions were written when the August 26, 2009 prescriptions were written for a 30 day supply.

e. R.J. presented to Respondent on October 7, 2009, with complaints of low back pain. Respondent refilled the prescriptions for OxyContin and Percocet at the same levels and increased the Xanax prescription from 60 to 90 tablets and prescribed a new medication, Adderall 20 mg, quantity 30. The records are absent an explanation for the increased quantity of Xanax.

f. R.J. presented to Respondent on November 9, 2009, to discuss x-ray findings though there is no x-ray report in R.J.'s chart. Respondent recommended a lumbar MRI.

g. On January 10, 2011, R.J. was seen by Respondent for complaints of right shoulder and low back pain. Respondent recommended that R.J. attend a support group in his office. Respondent refilled R.J.'s medications, increasing the quantity of the Adderall prescription from 60 tablets to 90 tablets⁵ and continuing to prescribe oxycodone quantity 90, Norco quantity 90 and Xanax quantity 60.

h. On February 10, 2011, R.J. was seen by Respondent with complaints that his symptoms had worsened and that he had begun taking six oxycodone daily instead of three oxycodone and three Norco. R.J.'s chart reflects that his pain intensity was two to four with medication and nine to 10 without medication. Respondent's primary diagnosis was lumbar facet syndrome. Respondent's plan was to refill R.J.'s medication and he instructed R.J. to continue chiropractic care and physical therapy on his own. Respondent increased R.J.'s prescriptions for oxycodone to 120 tablets, Norco to 120 tablets, and Xanax to 90 tablets. Respondent also refilled and increased R.J.'s Adderall at 90 tablets to 120 tablets. No reason is noted in the chart for the increased dosages of the medications.

i. R.J. presented to Respondent on March 3, 2011, 21 days after his last visit and Respondent refilled R.J.'s oxycodone, Norco, Xanax and Adderall at the same quantities even though the prescriptions from February 10, 2011, had been for a 30 day supply of drugs. R.J.'s chart reflects that R.J. was going out of town for two weeks so he presented early for a refill of his medications. Thereafter, R.J. should have been kept on his original medication schedule with refills being due on approximately April 8, 2011; however, Respondent refilled R.J.'s medications early on March 30, 2011. The March 30, 2011 note also sets forth a notation of "DUI" in the pain history section. At the time of his Medical Board Interview, Respondent indicated that he did not know the meaning of "DUI" in the note.

⁵ It was not clear from the records when the quantity was increased to 60 from 30.

j. R.J. was seen by Respondent on May 16, 2011. The pain history section of the notation is illegible. At the time of this visit, Respondent recommended reducing R.J.'s medications but prescribed the same quantity of oxycodone, Norco and Adderall. He changed Soma 350 mg, quantity 90, for Xanax without a documented explanation for the change.

k. R.J. was seen by Respondent on June 22, 2011, at which time Respondent noted that R.J. was out of medications. Respondent issued prescriptions for oxycodone, Norco, Soma, and Adderall in the quantities previously prescribed.

l. On July 20, 2011, R.J. presented to Respondent with complaints of pain in the right shoulder and low back. Respondent switched R.J.'s prescription of Soma back to Xanax but the notation regarding Xanax in the plan section is illegible. In addition to prescribing Xanax, Respondent prescribed Adderall, oxycodone and Norco. While the office visit note reflects the date of July 20, 2011, the prescriptions are dated July 19, 2011.

m. On August 16, 2011, R.J. presented to Respondent and reported that his medications had been stolen from his medicine cabinet and he had been without medications for one week. Respondent recommended that R.J. reduce his medications but refilled R.J.'s medications at the same quantities previously prescribed. This was R.J.'s last noted visit to Respondent's office.

n. Respondent failed to provide proper oversight in monitoring R.J.'s use of controlled substances.

Extreme Departures-Patient T.S.

9. As more fully set forth in the Legal Conclusions, Respondent is subject to disciplinary action under Business and Professions Code (Code) Section 2234, subdivision (b), in that he engaged in extreme departures from the standard of care, which, in the statute, are characterized as gross negligence, in the treatment of patient T.S. Respondent failed to:

- a. Appropriately prescribe controlled substances for chronic pain conditions;
- b. Obtain a full substance abuse history;
- c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
- d. Establish medical indications for the use of opioids;
- e. Justify the need for controlled substances;
- f. Establish a treatment plan and objectives for the use of opioids;

- g. Periodically review the course of pain treatment and make appropriate modifications in treatment based on T.S.'s progress or lack of progress;
- h. Obtain additional evaluations and consultations from other physicians as required, when dealing with complex medical pain problems;
- i. Review information pertaining to the use of controlled substances, including CURES reports on a periodic basis; and
- j. Make further inquiry over the course of treatment when urine screens showed significant discrepancies and inconsistencies were discovered.

Repeated Simple Departures-Patients T.S., J.C., K.D. and R.J.

10. As more fully set forth in the Legal Conclusions, Respondent is subject to disciplinary action under Code Section 2234, subdivision (c), in that he engaged in repeated simple departures from the standard of care, which are characterized in the statute as "negligent acts," in the treatment of patients T.S., J.C., K.D. and R. J. The circumstances are as follows:

Patient T.S.

- 11. With respect to Patient T.S., Respondent failed to:
 - a. Appropriately prescribe controlled substances for chronic pain conditions;
 - b. Obtain a full substance abuse history;
 - c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
 - d. Establish medical indications for the use of opioids;
 - e. Justify the need for controlled substances;
 - f. Establish a treatment plan and objectives for the use of opioids;
 - g. Periodically review the course of pain treatment and make appropriate modifications in treatment based on T.S.'s progress or lack of progress;
 - h. Obtain additional evaluations and consultations from other physicians, as required, when dealing with complex medical pain problems;
 - i. Review information pertaining to the use of controlled substances, including CURES reports, on a periodic basis; and

j. Make further inquiry over the course of treatment when urine screens showed significant discrepancies and inconsistencies were discovered.

Patient J.C.

12. With respect to Patient J.C., Respondent failed to:

- a. Appropriately prescribe controlled substances for chronic pain conditions;
- b. Obtain a full substance abuse history;
- c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
- d. Justify the need for controlled substances;
- e. Periodically review the course of pain treatment and make appropriate modifications in treatment based on J.C.'s progress or lack of progress;
- f. Require a urine screen before prescribing controlled substances;
- g. Issued prescriptions for multiple sedatives, including two benzodiazepines and Soma, and increased her opioid prescriptions without documented medical indication;
- h. Document the need for concurrent Valium and Xanax prescriptions;
- i. Changed J.C.'s prescriptions from 30 mg of hydrocodone per day to 120 mg of morphine per day without an explanation in the record; and
- j. Discuss or document J.C.'s falling incident in relation to her medical regimen.

Patient K.D.

13. With respect to performing epidural injections on K.D.:

- a. Respondent failed to obtain or review spinal imaging prior to performing epidural injections on K.D. in order to come to a definitive diagnosis and more precisely target the source of pain prior to performing the procedure.
- b. Respondent administered steroid injections to K.D. in excess. From December 2007 through December 2008, Respondent administered steroid injections a total of 10 times. Further, on several occasions, he administered multiple doses of steroids on the same day to different anatomic locations.

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c. Respondent arbitrarily performed a series of epidural injections without interval assessment of treatment efficacy. There is no documentation of interval patient assessment of K.D. between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

Patient R.J.

14. Respondent failed to comply with the standard of care for prescribing controlled substances to R.J., in that Respondent failed to provide proper oversight in monitoring R.J.'s use of controlled substances.

Excessive Administration of Drugs or Treatment - Patient K.D.

15. Respondent excessively administered drugs or treatment to K.D. The circumstances are as follows:

a. Respondent administered steroid injections to K.D. in excess. On several occasions, he administered multiple doses of steroids on the same day to different anatomic locations.

b. Respondent arbitrarily performed a series of epidural injections without interval assessment of treatment efficacy. There is no documentation of interval patient assessment of K.D. between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

Failure to Maintain Adequate and Accurate Records - Patients T.S., J.C., K.D. and R.J.

16. Respondent failed to maintain adequate and accurate medical records as follows:

a. Respondent made errors in prescribed medications listed on submitted forms in relation to the urine tests for patient T.S., and all of Respondent's follow-up reports are hand written on preprinted forms and circled words on the form do not indicate positive or negative findings.

b. Some of the handwritten reports for T.S. are signed by both M.S., D.C. and Respondent, and it cannot be determined which provider was documenting findings and making recommendations.

c. Respondent's treatment plan and objectives for J.C. did not meet standard of care requirements that the records contain stated objectives, and all of Respondent's follow-up reports are hand-written on preprinted forms and circled words on the form do not indicate positive or negative findings.

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d. Respondent's medical records for K.D. reflect no documentation of interval patient assessment between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

e. Respondent recorded treatment plans at each of K.D.'s visits, but failed to describe the objectives of treatment over the course of treating K.D. Further, Respondent's medical records for K.D. are nearly illegible and fail to document standard guidelines in the use of controlled substances for patients with chronic pain conditions.

f. Multiple notations regarding Respondent's care and treatment of R.J. are illegible.

Petition to Revoke Probation

17. Respondent's current probationary terms include the following restriction on his prescribing Schedule II and III controlled substances:⁶

CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any Schedule II or Schedule III controlled substances as defined by the California Uniform Controlled Substances Act, except in the perioperative setting when Respondent is acting as anesthesiologist for a patient where the patient will only use such controlled substances at the location of the procedure (i.e., the foregoing exception shall not apply to any controlled substances that are used outside of such perioperative setting). Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that

⁶ There are five Schedules (classifications), of drugs, with varying qualifications for a substance to be included in each. Two federal agencies, the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA), determine which substances are added to or removed from the various schedules beginning with illegal drugs (eg marijuana) which are all Schedule I drugs. All other drugs are scheduled based on their potential for addictiveness and abuse with the most addictive drugs (such as morphine) being on Schedule II, and so forth.

Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

18. It is alleged that Respondent's probation is subject to revocation because he failed to comply with Condition 1 of the August 22, 2013 Decision referenced above. The facts and circumstances of this violation were proven by a preponderance of the evidence. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434, 1441.)

19. Respondent hired a nurse practitioner, Tina Girard (NP Girard), who had her own DEA license and ability to prescribe Schedule II and III controlled substances in an effort to circumvent the prescribing restriction. Despite the prescribing restriction ordered by the Board, Respondent continued to prescribe controlled substances to patients using NP Girard's prescription pad.

Testimony of Respondent's Medical Assistant - Taylor Hoag

20. Taylor Hoag testified that he witnessed Respondent writing prescriptions on NP Girard's prescription pad on more than one occasion at Respondent's Fresno office. Mr. Hoag was a medical assistant at Respondent's Fresno office from December 2013 to September 26, 2014. He worked Mondays through Fridays, 9:00 a.m. to 5:00 p.m., 40 hours a week. His duties included escorting patients to examination rooms, taking vital signs, answering the phones, cleaning patient examination rooms, answering patient questions and filing documents in patient charts, including placing a carbon copy of prescriptions given to patients. Mr. Hoag testified that when he began working at Respondent's office, he was not aware that Respondent was on probation with the Board. At the end of January 2014, Mr. Hoag learned that Respondent was on probation. He then read the Decision on the Board's website and learned that Respondent was not permitted to prescribe Schedule II and III controlled substances. Mr. Hoag had observed that Respondent wrote schedule II and III prescriptions on NP Girard's prescription pad.⁷ On days when NP was not in the office, Mr. Hoag observed Respondent seeing patients and then giving these same patients prescriptions written on NP Girard's prescription pad. Mr. Hoag called the Board and reported that Respondent was giving patients prescriptions on NP's pad on days that NP Girard was not in the office.

⁷ While Mr. Hoag might not have been able to observe the actual writing of the prescriptions, he was able to observe that Respondent entered an examination room to which the patient had been escorted, and he thereafter filed in the patient's chart a copy of the prescription the patient had been given after being examined.

21. Mr. Hoag testified that he then started keeping track of patients that he observed being seen by Respondent and given prescriptions for controlled substances by Respondent on NP Girard's prescription pad on days that NP Girard was not in the office. Mr. Hoag provided the notes he made on a copy of Respondent's Fresno office schedule to Board Investigator Jerome Hull, identifying dates that NP Girard was not present in the office and the names of patients seen by Respondent on those dates. (Exhibits 70 and 73.) Mr. Hoag never provided Investigator Hull any medical records for any patient.

22. On Thursday, February 27, 2014, NP Girard was not in the office. (Exhibit 70, p.2.) That day, Mr. Hoag observed that patient K.J. was seen by Respondent and issued a prescription by Respondent for Schedule II drugs Norco, Opana IR and Opana ER on NP Girard's prescription pad. (Exhibit 100.) In addition, that same day, Mr. Hoag also observed that patient W.C. was seen by Respondent and issued a prescription by Respondent for Norco, morphine sulfate ER (another Schedule II drug) and Restoril on NP Girard's prescription pad. (Exhibit 92.) On Wednesday, March 5, 2014, NP Girard was not in the office. (Exhibit 70, p.3.) That day, Mr. Hoag observed that patient R.M. was seen by Respondent and issued a prescription by Respondent for Norco, Flexeril and Nucynta ER (Schedule II) on NP Girard's prescription pad. (Exhibit 94.) On Thursday, March 6, 2014, NP Girard was not in the office. (Exhibit 70, p.4.) That day, Mr. Hoag observed that patient S.P. was seen by Respondent and issued a prescription by Respondent for morphine sulfate IR, morphine sulfate ER (both Schedule II drugs) and Flexeril on NP Girard's prescription pad. (Exhibit 97.) That same day, Mr. Hoag also observed that patient E.M. was seen by Respondent and issued a prescription by Respondent for OxyContin, Roxicodone (both Schedule II drugs) and Tizanidine on NP Girard's prescription pad. (Exhibit 99.)

23. On Wednesday, March 12, 2014, NP Girard was not in the office. (Exhibit 70, p.5.) That day, Mr. Hoag observed that patient E.A. was seen by Respondent and issued a prescription by Respondent for hydrocodone-acetaminophen (Schedule II) on NP Girard's prescription pad. (Exhibit 90, p.1.) That day, Mr. Hoag also observed that patient L.H. was seen by Respondent and issued a prescription by Respondent for Opana ER and Norco on NP Girard's prescription pad. (Exhibit 96.) On Thursday, July 17, 2014, NP Girard was not in the office. (Exhibit 73.) That day, Mr. Hoag observed that patient C.A. was seen by Respondent and issued a prescription by Respondent for morphine sulfate ER, Baclofen and Elavil on NP Girard's prescription pad. (Exhibit 108.) That day, Mr. Hoag also observed that patient T.C. was seen by Respondent and issued a prescription by Respondent for Norco, Flexeril and ibuprofen 800 mg on NP Girard's prescription pad. (Exhibit 103)

24. Mr. Hoag called Investigator Hull numerous times in May, June, July, August and September 2014 to provide him with the names of additional patients that were seen by Respondent and who were issued prescriptions by Respondent on NP Girard's prescription pad on days that she was not in the office. On Thursday, May 15, 2014, NP Girard was not in the office. That day, Mr. Hoag observed that patient L.W. was seen by Respondent and issued a prescription by Respondent for morphine sulfate ER, Cymbalta and docusate (a stool softener) on NP Girard's prescription pad (Exhibit 101.) That day, Mr. Hoag also observed that patient E.A. was seen by Respondent and issued a prescription by Respondent for

hydrocodone-acetaminophen on NP Girard's prescription pad. (Exhibit 90, p.2.) In addition that day, Mr. Hoag observed that patient R.S. was seen by Respondent and issued a prescription for hydrocodone-acetaminophen on NP Girard's prescription pad. (Exhibit 91.)

25. On Thursday, July 31, 2014, NP Girard was not in the office. That day, Mr. Hoag observed that patient S.T. was seen by Respondent and issued a prescription by Respondent for Amrix (a muscle relaxant), Xanax and Norco on NP Girard's prescription pad. (Exhibit 104.) On Thursday, August 14, 2014, NP Girard was not in the office. That day, Mr. Hoag observed that patient L.S. was seen by Respondent and issued a prescription by Respondent for hydrocodone-acetaminophen and Cymbalta on NP Girard's prescription pad. (Exhibit 105.) That day, Mr. Hoag also observed that patient M.C. was seen by Respondent and issued a prescription by Respondent for hydrocodone-acetaminophen and ibuprofen 600 mg on NP Girard's prescription pad. (Exhibit 109.) On Wednesday, August 20, 2014, NP Girard was not in the office. That day, Mr. Hoag observed that patient E.A. was seen by Respondent and issued a prescription by Respondent for Norco and naproxen on NP Girard's prescription pad. (Exhibit 107.)

*Testimony of Respondent's Former Newport Beach Office Patient - Kr.De.*⁸

26. Patient Kr.De. testified that she received care and treatment from Respondent from approximately 2012 to September 2014 at his Newport Beach office. She saw Respondent approximately once a month for evaluation and medication refills. As part of her pain management regimen, she was taking OxyContin and morphine sulfate. Patient Kr.De. testified that she had never been treated by NP Girard. Further, she was never examined by or treated with a nurse practitioner at Respondent's office. The only female health care provider that patient Kr.De. saw in Respondent's office was Ashley, who was Respondent's medical assistant and receptionist. Ashley's involvement in patient Kr.De.'s care was limited to taking patient Kr.De. to the examination room before exams and taking patient Kr.De.'s blood pressure.

27. Patient Kr.De. testified that she received a prescription for OxyContin and morphine sulfate at the time of her May 12, 2014 office visit with Respondent and she filled the prescription on May 13, 2014, at Rite Aid Pharmacy. While patient Kr.De. does not know who wrote the prescription and does not recognize the handwriting on the prescription, she was not seen by NP Girard on May 12, 2014, but the prescription she received was issued from NP Girard's prescription pad. (Exhibit 112, page 1.) Patient Kr.De. testified that she also received a prescription for OxyContin and morphine sulfate at the time of her June 10, 2014 office visit with Respondent and she filled the prescription on June 11, 2014, at Rite Aid Pharmacy. While patient Kr.De. does not know who wrote the prescription and does not recognize the handwriting on the prescription, she was not seen by NP Girard on June 10,

⁸ Patient Kr.De., who testified on June 21, 2016, is identified as such to distinguish her from patient "K.D." who is identified in the Second, Third and Fourth Causes for Discipline set forth in the First Amended Accusation.

2014, but the prescription she received was issued from NP Girard's prescription pad. (Exhibit 112, page 2.) Patient Kr.De. testified that she again received a prescription for OxyContin and morphine sulfate at the time of her July 9, 2014 office visit with Respondent and she filled the prescription that same day at Rite Aid Pharmacy. While patient Kr.De. does not know who wrote the prescription and does not recognize the handwriting on the prescription, she was not seen by NP Girard on July 9, 2014, but the prescription she received was issued from NP Girard's prescription pad. (Exhibit 112, page 3.)

28. Patient Kr.De. testified that she received a prescription for OxyContin and morphine sulfate at the time of her August 7, 2014 office visit with Respondent and she filled the prescription that same day at Rite Aid Pharmacy. While patient Kr.De. does not know who wrote the prescription and does not recognize the handwriting on the prescription, she was not seen by NP Girard on August 7, 2014, but the prescription she received was issued from NP Girard's prescription pad. (Exhibit 112, page 4.) Patient Kr.De. testified that she received a prescription for OxyContin and morphine sulfate at the time of her September 4, 2014 office visit with Respondent and she filled the prescription that same day at Rite Aid Pharmacy. While patient Kr.De. does not know who wrote the prescription and does not recognize the handwriting on the prescription, she was not seen by NP Girard on September 4, 2014, but the prescription she received was issued from NP Girard's prescription pad. (Exhibit 112, page 5.)

29. Respondent did not disclose to patient Kr.De., at any point during the time she treated with him, that he was on probation with the Board and was prohibited from prescribing OxyContin and morphine sulfate.

Testimony of Los Angeles Sheriff's Department Forensic Document Examiner Barbara Torres.

30. Barbara Torres, a forensic document examiner with the Los Angeles Sheriff's Department, has been a forensic document examiner for 40 years. From 1977 to the present, she has testified in court on approximately 138 occasions. (Exhibit 126.) Ms. Torres was asked to examine original prescriptions (Exhibits 90, 91, 92, 94, 96, 100, 101, 103, 104, 105, 106, 107, 108, 109, 111 (page 1), and 112.) These prescriptions were all written on NP Girard's prescription pad and all contained prescriptions for at least one Schedule II drug. She was also given exemplars of prescriptions written by Respondent as well as the Board Information Summary Questionnaire that Respondent filled out as part of his probation, in order to compare the writing on the prescriptions with known writing of Respondent. (Exhibits 32 (page 1), 15 (page 1), 67 (pages 1-2) and 87 (page 4).) Upon completion of her examination, Ms. Torres concluded that "[t]here is substantial evidence that the questioned writing [on the prescriptions written on NP Girard's prescription pad], excluding the few overwritten characters, was probably produced by the writer of the exemplars." Ms. Torres noted that there were sufficient similarities to establish a strong likelihood that the writer of the exemplar hand printing produced the questioned hand printing on the prescription. In other words, the writing or printing on the original prescriptions examined by Ms. Torres was that of Respondent.

31. In addition to the handwriting comparison of the questioned entries, Ms. Torres examined the optical ink properties on the submitted prescriptions. She noted that optically different inks were used on each of the prescriptions she examined. That is, different inks were used on the same prescription. She found pronounced optical distinction between the ink of the signatures versus the ink used on the "recipe writing."⁹ For example, on the prescription dated March 12, 2014, for patient E.A., the signature and date slashes between the spaces for entering the month, day and year (i.e., / /) as well as the year (i.e., / /14) have similar optical properties which are distinguishable from the optical properties of the patient's name and prescription "recipe," as well as the numbers representing the month and day which were inserted between the date slashes. (Exhibit 90.) The same optical properties are noted on the May 15, 2014 prescription for patient R.S. (Exhibit 91) and the March 12, 2014 prescription for patient L.S. (Exhibit 96.) And in some instances, the signature and date slashes had similar optical properties while the recipe and the actual numbers for the dates had distinguishable optical properties, such as the prescriptions for patient K.A. dated February 25, 2014 marked as page 1 of Exhibit 111. Ms. Torres also pointed out that the optical properties show an awkward preparation method of prescription writing. In general, it is not natural for an individual to sign a document and insert the slash marks for the date without actually writing the date at the same time the slashes are created.

*Testimony of Respondent*¹⁰

32. Following the compelling testimony of Ms. Torres, Respondent "revised" his prior testimony. Respondent originally testified that he reviewed his Stipulated Settlement and Disciplinary Order and that he clearly understood that a condition of his probation was that he was not to prescribe Schedule II and III controlled substances in his office setting. He denied that he hired a nurse practitioner so that he could circumvent his prescribing prescriptions. Respondent testified that NP Girard had a DEA license that permitted her to prescribe Schedule II and III controlled substances. She kept her own prescription pads and

⁹ "Recipe" was the name the witness gave the actual prescription portion of the questioned document to distinguish that writing from the signature, date and any other writing on the document.

¹⁰ Respondent vigorously argued that Ms. Torres' testimony should have been presented in Complainant's case in chief before Respondent testified. That argument is rejected. Complainant had no reason to call a questioned documents expert until Respondent repeatedly denied that not only did he not write prescriptions on NP Girard's prescription pads, but that he never had access to them at all. Respondent's argument is, in essence, that he was not given the opportunity to tailor his initial testimony to dovetail it with Ms. Torres' testimony, so that he would not have to recant some, if not all, of his original testimony. What makes the argument so profoundly disingenuous is that all prescriptions, including those with Respondent's handwriting on NP Girard's prescription forms, were turned over to Respondent during pretrial discovery. He only had to look at them to see that he not only had access to NP Girard's prescription pads, he actually wrote on them.

he did not have access to NP Girard's prescription pads. On December 15, 2016, Respondent testified that he had never written on NP Girard's prescription pads. On cross-examination in March 2016, Respondent confirmed that he never wrote on NP Girard's prescription pads and did not have access to them. On March 21, 2016, Respondent reviewed Exhibits 90-100 in Complainant's Exhibits and confirmed that none of the writing on those prescriptions was his writing. Respondent also reviewed Exhibits 101-112 and confirmed that none of the writing on those prescriptions was his writing.

33. However, following the rebuttal testimony of forensic document examiner Barbara Torres, Respondent, over the objection of Complainant, returned to the witness stand and testified that while he never forged the signature of NP Girard on her prescription pads, the prescriptions examined by Ms. Torres did in fact have his handwriting in the body of the prescriptions. He admitted that he wrote the body of the prescription "recipe," claiming that he copied the prescription from the various patients' previous month's prescriptions as set forth in their charts and that NP Girard then signed the prescriptions. He explained that he was simply assisting NP Girard on days when she was not in the office and sometimes on days when she was in the office. He testified that NP Girard had already examined some of the patients and she had authorized the refills. He also testified that some of the patients would be examined by other practitioners and then NP Girard would review and sign the already filled out prescriptions. Respondent was unable to consistently articulate the reason he wrote Schedule II and III controlled substance prescriptions for NP Girard. Further, at times during trial, Respondent testified that NP Girard independently examined the patients who were prescribed Schedule II and III controlled substances, and at other times during trial, Respondent testified that NP Girard would only review patient charts and not examine the patients who were being prescribed Schedule II and III controlled substances. His shifting explanations were virtually impossible to follow.

Respondent was Dishonest in his Quarterly Reports

34. Condition 11 of the August 22, 2013 Decision and Order requires that Respondent submit Quarterly Declarations, under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of his probation. Inspector Jimenez testified that on September 19, 2013, when she met with Respondent to review the terms and conditions of his probation, she discussed Term and Condition No. 11. She read it out loud to Respondent and asked if he had any questions. Respondent did not have any questions. She testified that she also reviewed the requirement that Respondent keep the Board informed of his business address at all times. Respondent signed the Acknowledgement of Decision confirming review and also signed The Quarterly Declaration Due Dates Acknowledgment, which sets forth "Failure to comply with the reporting requirements is a violation of probation and is grounds for administrative action to revoke probation and carry out the Decision that was stayed." (Exhibit 87, page 264.) Respondent testified that he read, understood and signed the Quarterly Declaration Reporting Requirements.

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35. Respondent failed to comply fully with Condition 11. While Respondent maintained a medical office in Fresno, California prior to the commencement of his probation on September 20, 2013, for nearly two years he failed to note in his Quarterly Declarations the Fresno address as a location where he practiced medicine.¹¹ It was not until April 21, 2015, at which time Respondent was told that the Board was aware that he had a Fresno office that he finally started filling out his declarations accurately.

36. Respondent argues that 1) the Board knew Respondent had a Fresno office; 2) Respondent was in the process of closing his Fresno office (which never happened—it is now his primary office); and 3) the failure to disclose that he practiced at the Fresno office, was de minimis. Each of those arguments individually may or may not have merit. However, the fact remains that Respondent was required to disclose that he practiced out of his Fresno office, and he failed to do so.

LEGAL CONCLUSIONS¹²

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standards of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it is sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. Complainant also bears the burden of proof to establish that cause exists to revoke probation in this administrative proceeding. The standard of proof in a proceeding to revoke probation is preponderance of the evidence. (*Sandarg v. Dental Board of California*

¹¹ See the Quarterly Declarations signed on October 1, 2013, January 1, 2013, April 3, 2014, July 7, 2014, October 5, 2014, January 5, 2015 and March 30, 2015.

¹² Findings 9 through 15 are incorporated herein by reference.

(2010) supra.) The phrase “preponderance of evidence” is usually defined in terms of probability of truth, e.g., “such evidence as, when weighed with that opposed to it, has more convincing force and the greater probability of truth.” (BAJI (8th ed.), No. 2.60; 1 Witkin, Evidence, Burden of Proof and Presumptions § 35 (4th ed. 2000).)

Applicable Statutes Regarding Causes to Impose Discipline

4. Code section 2227, subdivision (a), states:

A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may in accordance with the provisions of this chapter:

- (1) Have his or her license revoked upon order of the board.
- (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
- (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
- (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
- (5) Have any other action taken in relation to the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

5. Code section 2234 provides in part:

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

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

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

6. Code section 2266 provides: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Code section 725, subdivision (a) provides, in part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon"

Decisional Authority Regarding Standards of Care

7. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App. 4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.)

8. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Incompetence has been defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Id.* at 1054)

9. Respondent violated the terms of his probation in Board case number 04-2011-219449 by his failure, on numerous occasions to refrain from prescribing Schedule II and III medications as set forth in Findings 19 through 32. These violations, separately and collectively, constitute grounds to vacate the stay order and impose the stayed discipline, revocation of his certificate to practice medicine.

10. Respondent violated the terms of his probation in Board case number 04-2011-219449 by his failure, on numerous occasions to disclose that he practiced medicine out of an office in Fresno, California as set forth in Findings 33 through 35. These violations, when coupled with the probation violations described in Legal Conclusion 9, constitute grounds to vacate the stay order and impose the stayed discipline, revocation of his certificate to practice medicine.

///

Gross Negligence-Patient T.S.

11. Respondent violated Code section 2234, subdivision (b), by committing acts of gross negligence when he failed to comply with the standard of care for prescribing controlled substances to T.S., in that Respondent failed to:

- a. Appropriately prescribe controlled substances for chronic pain conditions;
- b. Obtain a full substance abuse history;
- c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
- d. Establish medical indications for the use of opioids;
- e. Justify the need for controlled substances;
- f. Establish a treatment plan and objectives for the use of opioids;
- g. Periodically review the course of pain treatment and make appropriate modifications in treatment based on T.S.'s progress or lack of progress;
- h. Obtain additional evaluations and consultations from other physicians as required, when dealing with complex medical pain problems;
- i. Review information pertaining to the use of controlled substances, including CURES reports on a periodic basis; and
- j. Make further inquiry over the course of treatment when urine screens showed significant discrepancies and inconsistencies were discovered.

Repeated Negligent Acts-Patients T.S., J.C., K.D. and R.J.

12. Respondent is subject to disciplinary action under Code Section 2234, subdivision (c), in that he engaged in repeated negligent acts in the treatment of patients T.S., J.C., K.D. and R. J. Respondent engaged in repeated negligent acts and thereby violated Code section 2234, subdivision (c), when he failed to comply with the standard of care for prescribing controlled substances to T.S., in that he failed to:

Patient T.S.

- a. Appropriately prescribe controlled substances for chronic pain conditions;
- b. Obtain a full substance abuse history;

- c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
- d. Establish medical indications for the use of opioids;
- e. Justify the need for controlled substances;
- f. Establish a treatment plan and objectives for the use of opioids;
- g. Periodically review the course of pain treatment and make appropriate modifications in treatment based on T.S.'s progress or lack of progress;
- h. Obtain additional evaluations and consultations from other physicians, as required, when dealing with complex medical pain problems;
- i. Review information pertaining to the use of controlled substances, including CURES reports, on a periodic basis; and
- j. Make further inquiry over the course of treatment when urine screens showed significant discrepancies and inconsistencies were discovered.

Patient J.C.

13. Respondent engaged in repeated negligent acts and thereby violated Code section 2234, subdivision (c), when he failed to comply with the standard of care for prescribing controlled substances to J.C., in that he failed to:

- a. Appropriately prescribe controlled substances for chronic pain conditions;
- b. Obtain a full substance abuse history;
- c. Discuss the risks and benefits of the use of controlled substances along with other treatment modalities;
- d. Justify the need for controlled substances;
- e. Periodically review the course of pain treatment and make appropriate modifications in treatment based on J.C.'s progress or lack of progress;
- f. Require a urine screen before prescribing controlled substances;
- g. Issued prescriptions for multiple sedatives, including two benzodiazepines, and Soma, and increased her opioid prescriptions without documented medical indication;
- h. Document the need for both Valium and Xanax prescriptions;

- i. Changed J.C.'s prescriptions from 30 mg of hydrocodone per day to 120 mg of morphine per day without an explanation in the record; and
- j. Discuss or document J.C.'s falling incident in relation to her medical regimen.

Patient K.D.

14. Respondent engaged in repeated negligent acts and thereby violated Code section 2234, subdivision (c), when he failed to comply with the standard of care for performing epidural injections on K.D., as follows:

a. Respondent failed to obtain or review spinal imaging prior to performing epidural injections on K.D. in order to come to a definitive diagnosis and more precisely target the source of pain prior to performing the procedure

b. Respondent administered steroid injections to K.D. in excess. From December 2007 through December 2008, Respondent administered steroid injections a total of 10 times. Further, on several occasions, he administered multiple doses of steroids on the same day to different anatomic locations.

c. Respondent arbitrarily performed a series of epidural injections without interval assessment of treatment efficacy. There is no documentation of interval patient assessment of K.D. between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

Patient R.J.

15. Respondent engaged in repeated negligent acts and thereby violated Code section 2234, subdivision (c), when he failed to comply with the standard of care for prescribing controlled substances to R.J., in that Respondent failed to provide proper oversight in monitoring R.J.'s use of controlled substances.

Excessive Administration of Drugs or Treatment - Patient K.D.

16. Respondent is subject to disciplinary action under Code section 725 in that he excessively administered drugs or treatment to K.D. The circumstances are as follows:

a. Respondent administered steroid injections to K.D. in excess. On several occasions, he administered multiple doses of steroids on the same day to different anatomic locations.

b. Respondent arbitrarily performed a series of epidural injections without interval assessment of treatment efficacy. There is no documentation of interval patient assessment of K.D. between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

Failure to Maintain Adequate and Accurate Records - Patients T.S., J.C., K.D. and R.J.

17. Respondent is subject to disciplinary action under Code Section 2266 for failure to maintain adequate and accurate medical records as follows:

a. Respondent made errors in prescribed medications listed on submitted forms in relation to the urine tests for patient T.S., and all of Respondent's follow-up reports are hand written on preprinted forms and circled words on the form do not indicate positive or negative findings.

b. Some of the handwritten reports for T.S. are signed by both M.S., D.C. and Respondent and it cannot be determined which provider was documenting findings and making recommendations.

c. Respondent's treatment plan and objectives for J.C. did not meet standard of care requirements that the records contain stated objectives, and all of Respondent's follow-up reports are hand-written on preprinted forms and circled words on the form do not indicate positive or negative findings.

d. Respondent's medical records for K.D. reflect no documentation of interval patient assessment between procedures and there is no documentation of assessment of treatment efficacy for the injections performed.

e. Respondent recorded treatment plans at each of K.D.'s visits, but failed to describe the objectives of treatment over the course of treating K.D. Further, Respondent's medical records for K.D. are nearly illegible and fail to document standard guidelines in the use of controlled substances for patients with chronic pain conditions.

f. Multiple notations regarding Respondent's care and treatment of R.J. are illegible.

18. Respondent abused the trust the Board placed in him when it put him on probation in the underlying action. His conduct, as set forth in Findings 19 through 24, and 29 through 34, coupled with the evident dishonesty in his testimony at the hearing of this matter, establishes that there is no reason to believe that if Respondent's probation were to remain in place, he would not abuse that trust again. Accordingly, the only possible disciplinary action that can be imposed for the protection of the public is revocation of Respondent's certificate to practice medicine.

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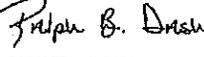
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ORDER

The stay of the revocation of Respondent's certificate to practice medicine imposed in Board case number 04-2011-219449 is vacated. Physician's and Surgeon's Certificate number G 68169 issued to John F. Petraglia, together with all licensing rights appurtenant thereto, is revoked.

DATED: July 19, 2017

DocuSigned by:

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RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings

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

11 In the Matter of the First Amended Accusation
and Petition to Revoke Probation Against:

Case No. 04-2013-229649

12 JOHN F. PETRAGLIA, M.D.

13 **FIRST AMENDED ACCUSATION AND**
14 **PETITION TO REVOKE PROBATION**

14 1601 Dove Street, Suite 170
Newport Beach, CA 92660

15 Physician's and Surgeon's Certificate No. G
16 68169,

17 Respondent.

18
19 Complainant alleges:

20 **PARTIES**

21 1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation and
22 Petition to Revoke Probation solely in her official capacity as the Executive Director of the
23 Medical Board of California, Department of Consumer Affairs.

24 2. On or about March 12, 1990, the Medical Board of California issued Physician's and
25 Surgeon's Certificate number G 68169 to John F. Petraglia, M.D. (Respondent). That License
26 was in full force and effect at all times relevant to the charges brought herein and will expire on
27 March 31, 2016, unless renewed.

28 ///

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

3 "..."

4 8. Code section 2227 provides:

5 "(a) A licensee whose matter has been heard by an administrative law judge of the Medical
6 Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default
7 has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary
8 action with the board, may, in accordance with the provisions of this chapter:

9 "(1) Have his or her license revoked upon order of the board.

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

12 "(3) Be placed on probation and be required to pay the costs of probation monitoring
13 upon order of the board.

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

16 "(5) Have any other action taken in relation to discipline as part of an order of
17 probation, as the board or an administrative law judge may deem proper.

18 "(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical
19 review or advisory conferences, professional competency examinations, continuing education
20 activities, and cost reimbursement associated therewith that are agreed to with the board and
21 successfully completed by the licensee, or other matters made confidential or privileged by
22 existing law, is deemed public, and shall be made available to the public by the board pursuant to
23 Section 803.1."
24

25
26
27 ///

28 ///

1 9. Section 2234 of the Code, states:

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

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

7 "(b) Gross negligence.

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

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

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

18 "(d) Incompetence.

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

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

22 "(g) The practice of medicine from this state into another state or country without meeting
23 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
24 apply to this subdivision. This subdivision shall become operative upon the implementation of
25 the proposed registration program described in Section 2052.5.

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

1 10. Section 2242 of the Code states:

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

5 "(b) No licensee shall be found to have committed unprofessional conduct within the
6 meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of
7 the following applies:

8 "(1) The licensee was a designated physician and surgeon or podiatrist serving in the
9 absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs
10 were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return
11 of his or her practitioner, but in any case no longer than 72 hours.

12 "(2) The licensee transmitted the order for the drugs to a registered nurse or to a
13 licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

14 "(A) The practitioner had consulted with the registered nurse or licensed
15 vocational nurse who had reviewed the patient's records.

16 "(B) The practitioner was designated as the practitioner to serve in the absence of
17 the patient's physician and surgeon or podiatrist, as the case may be.

18 "(3) The licensee was a designated practitioner serving in the absence of the patient's
19 physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized
20 the patient's records and ordered the renewal of a medically indicated prescription for an amount
21 not exceeding the original prescription in strength or amount or for more than one refill.

22 "(4) The licensee was acting in accordance with Section 120582 of the Health and
23 Safety Code."

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

27 ///

28 ///

1 12. Business and Professions Code section 725 provides:

2 "(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering
3 of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated
4 acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of
5 the community of licensees is unprofessional conduct for a physician and surgeon, dentist,
6 podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language
7 pathologist, or audiologist.

8 "(b) Any person who engages in repeated acts of clearly excessive prescribing or
9 administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of
10 not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by
11 imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and
12 imprisonment.

13 "(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or
14 administering dangerous drugs or prescription controlled substances shall not be subject to
15 disciplinary action or prosecution under this section.

16 "(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section
17 for treating intractable pain in compliance with Section 2241.5."

18 **CONTROLLED SUBSTANCES/DANGEROUS DRUGS**

19 13. Code section 4021 states:

20 "'Controlled substance' means any substance listed in chapter 2 (commencing with Section
21 11053) of Division 10 of the Health and Safety Code."

22 14. Code section 4022 provides:

23 "'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in
24 humans or animals, and includes the following:

25 "(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without
26 prescription,' 'Rx only' or words of similar import.

27 "(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale
28 by or on the order of a _____,' 'Rx only,' or words of similar import . . .

1 c. Respondent's actual care of T.S. included *inter alia* a lumbar epidural steroid
2 injection and hydrocodone, which was later switched to oxycodone. Refills of medications
3 prescribed by Respondent occurred approximately every 21 days during T.S.'s treatment.

4 d. Three urine screens reflected in T.S.'s medical records were all sent to
5 Calloway Laboratory for analysis. The first urine screen in the records was done on October 17,
6 2011. There were multiple inconsistencies in the reported urine results including a negative result
7 for alprazolam, which was prescribed to T.S. by Respondent on September 27, 2011. In addition,
8 the urine results showed a positive opioid level. Although oxycodone is a synthetic opioid, it
9 does not usually trigger a positive opioid result on a lab test unless the patient is taking high
10 doses. The urine results also showed positive for tramadol,⁷ which was not prescribed to T.S. by
11 anyone. Lastly, the report shows that the oxymorphone level was nearly three times higher than
12 the oxycodone level, which indicates that higher than prescribed doses were being taken, which
13 Respondent should have taken note of.

14 e. The second urine screen was done on November 2, 2011. Respondent again
15 noted that the patient's medications listed in the urine screen report were wrong, but failed to
16 address that issue. Respondent noted that the report erroneously listed that the patient is taking
17 Norco and failed to list that the patient is taking alprazolam. Additional inconsistencies in this
18 report are a positive hydromorphone level which was not being prescribed and cannot be
19 explained by opioid metabolism. The high level of oxymorphone compared to oxycodone, as was
20 shown on the initial report, is again reflected in the second report and reflects a higher dose than
21 that being prescribed. Respondent failed to address these issues with T.S.

22 f. The third urine screen occurred on November 29, 2011, and again showed a
23 very high oxymorphone level.

24 g. Respondent negligently failed to comply with the standard of care for
25 prescribing controlled substances to T.S. by failing to follow the standard of care for prescribing

26 _____
27 ⁷ Tramadol is an opioid analgesic used for the treatment of pain following surgical procedures and oral
28 surgery.

1 controlled substances for chronic pain conditions. The standard of care in the community
2 requires:

- 3 1. A medical history and physical exam, including an assessment of the
4 patient's pain, including physical and psychological status and function;
- 5 2. The patient's substance abuse history;
- 6 3. A history of prior treatments and an assessment of any other underlying
7 or co-existing conditions; and
- 8 4. Documentation of recognized medical indications for the use of
9 controlled substances such as opiates for pain control.

10 h. Respondent negligently failed to get a full substance abuse history and failed to
11 justify the need for controlled substances. T.S. indicated on her intake questionnaire that she had
12 no substance abuse history, but no further inquiry was made by Respondent over the course of
13 treatment despite the urine test result inconsistencies.

14 i. Respondent negligently failed to establish medical indications for the use of
15 opioids that are not clear through the history, physical exam, or MRI findings.

16 j. Respondent was negligent in that his treatment plan and objectives did not meet
17 the Board's requirements that the medical records contain stated objectives. All of Respondent's
18 follow-up reports are hand-written on preprinted forms and circled words on the form do not
19 indicate positive or negative findings. Furthermore, when findings were not circled it cannot be
20 determined if those findings were negative or were not tested. Lastly, some of the hand-written
21 reports are signed by both M.S., D.C. and Respondent, and it cannot be determined which
22 provider was documenting findings and making recommendations.

23 k. Respondent negligently failed to discuss the risks and benefits of the use of
24 controlled substances along with other treatment modalities with T.S. The record does not
25 contain an opioid agreement and there is no indication that the risks, benefits and alternatives to
26 controlled substances were discussed with T.S.

27 l. Respondent was grossly negligent in that he failed to periodically review the
28 course of pain treatment for T.S. and failed to make appropriate modifications in T.S.'s treatment

1 based on T.S.'s progress or lack of progress. Respondent failed to review information pertaining
2 to use of controlled substances, including CURES reports on a periodic basis.

3 m. Respondent was grossly negligent in that he obtained three urine screens that
4 showed significant discrepancies and neither did he identify the discrepancies or address those
5 discrepancies. The record shows that T.S. was receiving opioids from two clinics, had positive
6 urine screens with substances not prescribed, and had claimed to have lost prescriptions requiring
7 an early refill. All of the facts indicate a need for evaluation of a substance abuse disorder, which
8 Respondent failed to identify.

9 n. Respondent was grossly negligent in that he failed to obtain additional
10 evaluations and consultations from other physicians, as required, when dealing with complex
11 medical pain problems. Although Respondent consulted with Dr. E.,⁸ they both continued to
12 provide controlled substances to T.S.

13 16. **Patient J.C.**

14 a. J.C. was a 52-year-old female patient who died on July 22, 2012. The cause of
15 death was an overdose from the combined effects of morphine, methamphetamine, amphetamine,
16 alprazolam, hydroxyalprazolam, diazepam,⁹ nordiazepam,¹⁰ oxazepam¹¹ and temazepam.¹²

17 b. J.C. first consulted with Respondent on October 26, 2011, with complaints of
18 neck, arm, back and knee pain. Her past medical history showed a prior cervical fusion and
19 surgery on the left humerus rodding, which resulted in a non-union. She also had cervical
20 stenosis,¹³ an unspecified birth defect, depression, and she smoked. At the time of her initial
21

22 ⁸ Dr. E., was T.S.'s prior treating physician.

23 ⁹ Diazepam is a benzodiazepine used as an anti-anxiety agent, sedative, anti-panic agent, anti-tremor agent,
skeletal muscle relaxant and anticonvulsant.

24 ¹⁰ Nordiazepam is a long-acting sedative/hypnotic.

25 ¹¹ Oxazepam is a benzodiazepine tranquilizer, used as an antianxiety.

26 ¹² Temazepam is a benzodiazepine used as a sedative and hypnotic in the treatment of insomnia.

27 ¹³ Cervical stenosis is a narrowing or complete closure of the canal between the body of the uterus and the
28 endocervical canal.

1 consultation, J.C. was using Xanax, Valium, Norco, Soma, and another medication unclear from
2 the records.

3 c. Respondent gave J.C. multiple cervical, shoulder, and neck injections on four
4 separate occasions without any documented benefit.

5 d. J.C.'s medical records reflect 3 CURES reports, dated October 26, 2011,
6 December 28, 2011, and June 11, 2012 received by Respondent. A comparison of the medical
7 records with the CURES reports show that J.C. did not fill prescriptions for Soma and morphine.
8 In addition, the clinical notes from J.C.'s consultations with Respondent on April 12, 2012, May
9 1, 2012 and July 16, 2012 are confusing as to whether Cymbalta¹⁴ and or Pristiq¹⁵ were
10 prescribed.

11 e. Respondent negligently failed to document any inquiry into J.C.'s substance
12 abuse history, failed to require a urine report before prescribing controlled substances for J.C.,
13 and then gave prescriptions for multiple sedatives including two benzodiazepines, Soma, and
14 increased her opioid prescriptions.

15 f. Respondent negligently failed to document the need for both Valium and Xanax
16 prescriptions. There is no mention in the medical records if those substances helped J.C. in the
17 past or if there were side effects, and no stated objective for their use was given.

18 g. Respondent was negligent in that his treatment plan and objectives did not meet
19 the Board's guideline requirements that the medical records contain stated objectives. All of
20 Respondent's follow-up reports are hand-written on preprinted forms and circled words on the
21 form do not indicate positive or negative findings. Furthermore, when findings are not circled it
22 cannot be determined if those findings were negative or were not tested. Lastly, on November 21,
23 2011, Respondent changed J.C.'s prescriptions from 30 mg of Hydrocodone per day to 120 mg of
24 morphine per day, a significant increase. On the next visit on December 28, 2011, J.C. reported
25 ///

26 ¹⁴ Cymbalta is an antidepressant.

27 ¹⁵ Pristiq is an antidepressant.

28

1 falling. However, Respondent did not discuss this incident's possible relation to her medical
2 regimen.

3 h. Respondent negligently failed to discuss the risks and benefits of the use of
4 controlled substances along with other treatment modalities with J.C. The record does not
5 contain an opioid agreement and there is no indication that the risks, benefits and alternatives to
6 controlled substances were discussed with J.C.

7 i. Respondent was negligent in that he failed to adequately review the course of
8 pain treatment for the patient and failed to make appropriate modifications in J.C.'s treatment
9 based on J.C.'s progress or lack of progress. J.C. reported a history of depression and was
10 referred to the clinic's psychologist, but no record of a meeting is found. The degree of
11 depression was not commented on. The reason why two benzodiazepines were required was not
12 documented.

13 17. **Patient K.D.**

14 a. On December 12, 2007, K.D., a then 42-year-old woman, first presented to
15 Respondent's office for a pain management evaluation. At that time, Respondent made a
16 diagnosis of status post motor vehicle accident with persistent increase in lower back pain, status
17 post anterior cervical discectomy and fusion at C4-5-6 with probable dislodgement disruption of
18 hardware after collision. Respondent recommended that K.D. have a cervical CAT scan and
19 consider lumbar epidural steroid injection for diagnostic purposes. He also considered cervical
20 facet injections and continuing K.D.'s oral medications of Soma, 1 to 4 tablets a day, and Norco,
21 10 mg, 1 to 6 tablets a day. He started K.D. on a trial of Lyrica and performed a right trigger
22 point, sacroiliac joint injection.

23 b. On January 10, 2008, K.D. presented to Respondent at Alliance Surgery Center
24 for injection therapy. Respondent performed the following procedures: (1) multi-level lumbar
25 epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural neuroplasty
26 procedure with fluoroscopy; (3) epidural lysis of adhesions and injection of epidural steroid; and
27 (4) epidurogram, fluoroscopy with evaluation of radiographs. K.D. also underwent mobilization
28 of her spine by chiropractor, Dr. J. Following the procedures, K.D. was instructed to call

1 Respondent's office for follow up consultation, re-evaluation and further recommendations. It
2 was noted that a second epidural was recommended if necessary and if pain and dysfunction
3 persist, Respondent would proceed to discogram study and potentially lumbar plasma-mediated
4 disc decompression with the recommendation of interventional pain management care on an
5 appropriate and evidence based method. K.D. was instructed to undergo possible re-injection as
6 needed, consider discogram study with disc decompression and physical therapy for current
7 exacerbation of symptoms twice a week for two weeks upon authorization from her worker's
8 compensation provider.

9 c. On January 10, 2008, Respondent made changes to K.D.'s opioid medication
10 regimen.

11 d. On January 29, 2008, K.D. presented to Respondent at either Alliance Surgical
12 Center or Orangewood Surgical Center for injection therapy.¹⁶ Respondent performed the
13 following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve
14 roots L3-S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3) epidural lysis of
15 adhesions and injection of epidural steroid; and (4) epidurogram, fluoroscopy with evaluation of
16 radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J. Following the
17 procedures, K.D. was instructed to call Respondent's office for follow up consultation, re-
18 evaluation and further recommendations. It was noted that if pain and dysfunction persist,
19 Respondent will proceed to discogram study and lumbar plasma-mediated disc decompression
20 with the recommendation of interventional pain management care on an appropriate and evidence
21 based method. K.D. was instructed to undergo possible re-injection as needed, consider
22 discogram study with disc decompression and physical therapy for current exacerbation of
23 symptoms twice a week for two weeks upon authorization from her worker's compensation
24 provider.

25 ///

26 ¹⁶ K.D.'s certified medical records from Orangewood Surgical Center documents the January 28, 2008
27 procedures on Alliance Surgical Center letterhead as well as Orangewood Surgical Center letterhead. K.D.'s
28 certified medical records from Respondent's office documents the January 28, 2008 procedures documented on
Alliance Surgical Center letterhead.

1 e. On February 12, 2008, K.D. presented to Respondent at Orangewood Surgical
2 Center for injection therapy. Respondent performed the following procedures: (1) multi-level
3 lumbar epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural
4 neuroplasty procedure with fluoroscopy; (3) epidural lysis of adhesions and injection of epidural
5 steroid; (4) injection of flank myofascial trigger points; and (5) epidurogram, fluoroscopy with
6 evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J.
7 Following the procedures, K.D. was instructed to call Respondent's office for follow up
8 consultation, re-evaluation and further recommendations. It was noted that if pain and
9 dysfunction persist, Respondent will proceed to discogram study and lumbar plasma-mediated
10 disc decompression with the recommendation of interventional pain management care on an
11 appropriate and evidence based method. K.D. was instructed to undergo possible re-injection as
12 needed, consider discogram study with disc decompression and physical therapy for current
13 exacerbation of symptoms twice a week for two weeks upon authorization from her worker's
14 compensation provider.

15 f. On March 10, 2008, K.D. was seen by Respondent at his office at which time
16 he performed a pain management evaluation and adjusted her opioid medications.

17 g. On March 18, 2008, K.D. presented to Respondent at either Orangewood
18 Surgical Center or Alliance Surgical Center for injection therapy.¹⁷ Respondent performed the
19 following procedures: (1) multi-level lumbar epidural catheter selective catheterization of nerve
20 roots L3, L4, L5 and S1; (2) lumbar epidural neuroplasty procedure with fluoroscopy; (3)
21 epidural lysis of adhesions/injection of epidural steroid; (4) epidurogram and fluoroscopy with
22 evaluation of radiographs; and (5) injection of trigger points of right flank and hip. K.D. also
23 underwent mobilization of her spine by chiropractor, Dr. J. Following the procedures, K.D. was
24 instructed to call Respondent's office for follow up consultation, re-evaluation and further
25 recommendations. She was instructed to undergo possible re-injection as needed, consider

26
27 ¹⁷ K.D.'s certified medical records from Orangewood Surgical Center document the March 18, 2008
28 procedures on Orangewood Surgical Center letterhead. K.D.'s certified medical records from Respondent's office
document the March 18, 2008 procedures documented on Alliance Surgical Center letterhead.

1 discogram study with disc decompression and physical therapy for current exacerbation of
2 symptoms twice a week for two weeks upon authorization from her worker's compensation
3 provider.

4 h. On May 6, 2008, K.D. presented to Respondent at Orangewood Surgical Center
5 for injection therapy. Respondent performed the following procedures: (1) multi-level lumbar
6 epidural catheter selective catheterization of nerve roots L3-S1; (2) lumbar epidural procedure
7 with fluoroscopy; (3) injection of epidural steroid; and (4) epidurogram, fluoroscopy with
8 evaluation of radiographs. K.D. also underwent mobilization of her spine by chiropractor, Dr. J.
9 Following the procedures, K.D. was instructed to call Respondent's office for follow up
10 consultation, re-evaluation and further recommendations. She was instructed to undergo physical
11 therapy twice a week for two weeks for current exacerbation of symptoms upon authorization
12 from her worker's compensation provider; undergo additional epidural if necessary and possible
13 re-injection; and consider discogram study with disc decompression if pain and dysfunction
14 persists.

15 i. On November 19, 2008, K.D. was seen by Respondent for a pain management
16 evaluation and at that time, he refilled her opioid medications.

17 j. On December 2, 2008, K.D. presented to Respondent at Orangewood Surgical
18 Center for injection therapy. At that time, Respondent performed the following procedures: (1)
19 bilateral lumbar L3, L4 and L5 Facet injections with medial branch nerve block with
20 arthrography; (2) bilateral sacroiliac joint injections with arthrography; (3) and fluoroscopy with
21 evaluation of radiographs. Following the procedures, K.D. was instructed to call Respondent's
22 office for re-evaluation and further recommendations. She was also instructed to continue
23 stretching as instructed; undergo physical therapy for current exacerbation of symptoms; and
24 facet and/or repeat epidural injection as needed. Respondent also noted that further
25 recommendations would follow based upon K.D.'s response to therapy.

26 k. On January 16, 2009, K.D. was seen by Respondent for pain and opioid
27 medication management.

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1 l. On February 24, 2009, K.D. presented to Respondent at Orangewood Surgical
2 Center for injection therapy. Respondent performed the following procedures: (1) bilateral
3 lumbar facet injections L3-4, L4-5, L5-S1 with medial branch nerve block with arthrogram study;
4 (2) bilateral sacroiliac joint injections with arthrogram study; and (3) fluoroscopy with evaluation
5 of hard copy of radiographs. Following the procedures, K.D. was instructed to call Respondent's
6 office for a follow up consultation, re-evaluation and further recommendations. Respondent
7 recommended physical therapy for current exacerbation of symptoms upon authorization from her
8 worker's compensation provider twice a week for two weeks; second epidural if necessary with
9 possible re-injection; discogram study with disc decompression procedure for presumed
10 discogenic pain syndrome; and follow up appointment with neurosurgical / orthopedic consult,
11 Dr. B.C.

12 m. On March 4, 2009, May 11, 2009, June 10, 2009, February 11, 2010 and
13 August 7, 2009, K.D. was seen by Respondent for evaluation and opioid medication management.

14 n. On February 23, 2010, K.D. presented to Respondent at Orangewood Surgical
15 Center for injection therapy. Respondent noted that K.D. has had multiple surgical interventions
16 to attempt to cure her condition without full relief of her symptom complex. Respondent
17 performed the following procedures: (1) a lumbar epidural multilevel catheterization of disc
18 levels 3-4, L4-5, L5-S1; (2) a lumbar epidural multi-level selective neuroplasty injection of nerve
19 roots L3, L4, L5 and S1; (3) epidurograph and evaluation of radiographs; (4) bilateral lumbar
20 facet injections at L3-L4, L4-L5, L5-S1 and medial branch nerve block; and (5) right lumbar
21 transforaminal selective nerve root steroid injection block at the right L5 level. Respondent
22 recommended additional epidural and facet block as medically necessary.

23 o. K.D. continued to treat with Respondent for pain management evaluation and
24 opioid medication management and was last seen by Respondent on May 17, 2011.

25 p. Respondent failed to comply with the standard of care for performing epidural
26 injections on K.D., as follows:

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1 1. The standard of care requires that a physician obtain and review spinal
2 imaging prior to performing epidural injections in order to come to a definitive diagnosis and
3 more precisely target the source of pain prior to performing the procedure.

4 2. The standard of care requires physicians to limit the total number of
5 steroid injections per year to minimize the systemic side effects of steroid administration.

6 3. The standard of care requires that a physician assess the clinical
7 effectiveness of spinal procedures before repeating them.

8 q. Respondent failed to obtain or review spinal imaging prior to performing
9 epidural injections on K.D.

10 r. Respondent administered steroid injections to K.D. in excess. From December
11 2007 through December 2008, Respondent administered steroid injections a total of ten (10)
12 times. Further, on several occasions, he administered multiple doses of steroids on the same day
13 to different anatomic locations.

14 s. Respondent arbitrarily performed a series of epidural injections without interval
15 assessment of treatment efficacy. There is no documentation of interval patient assessment of
16 K.D. between procedures and there is no documentation of assessment of treatment efficacy for
17 the injections performed.

18 t. Respondent recorded treatment plans at each of K.D.'s visit, but failed to
19 describe the objectives of treatment over the course of treating K.D. Further, Respondent's
20 medical records for K.D. are nearly illegible and fail to document standard guidelines in the use
21 of controlled substances for patients with chronic pain conditions.

22 18. **Patient R.J.**

23 a. Patient R.J., a then 24-year-old male, first presented to Respondent on August
24 26, 2009 for an evaluation of lower back pain, left elbow pain, and headaches. Respondent noted
25 that the patient had a history of multiple injuries and had been maintained on medications by
26 different pain management physicians in the past. Respondent noted that the patient wanted to
27 lower his medication intake and was open to chiropractic care, low intensity laser therapy and
28 other alternative options. Respondent performed a physical examination. Respondent's

1 impressions were lumbar disc injury, mechanical back pain with facet arthrosis, lumbar muscle
2 spasm with myofascial pain syndrome, sleep disorder, mild depression, history of cigarette
3 smoking, history of left fifth finger tendon hood derangement, history of right elbow fracture,
4 olecranon bursitis, cervical spasm, and history of attention deficit disorder. Respondent
5 recommended diagnostic testing with lumbar MRI and elbow x-rays. R.J. signed an opioid
6 therapy consent form, a treatment agreement for use of opioid medications and a generic
7 procedure consent form.

8 b. At the time of the initial consultation on August 26, 2009, Respondent
9 prescribed OxyContin 40 mg quantity 60 with instruction to take one tablet twice daily, Xanax 2
10 mg quantity 60 with instruction to take one every 4 to 6 hours as needed for pain. Respondent did
11 not obtain a urine drug screen or a CURES report when he first examined the patient.

12 c. Respondent saw the patient for thirteen additional visits from September 9,
13 2009 through August 16, 2011. Aside from the first consultation on August 26, 2009,
14 Respondent's progress notes were on pre-printed templates using a checkbox format with
15 illegible handwritten comments, some of which were difficult even for Respondent to read when
16 he was asked about them during his Medical Board interview.

17 d. R.J. presented to Respondent on September 9, 2009 with complaints of low
18 back pain with his pain intensity being 7 on a scale of 1 to 10. Respondent recommended
19 physical therapy and a lumbar epidural injection in addition to refilling the patient's medications.
20 Respondent prescribed OxyContin 40 mg quantity 60, Xanax 2 mg quantity 60, and Percocet 10
21 mg/325 mg quantity 120. While the prescription is dated September 9, 2009, the medication log
22 reflects that the medications were prescribed on September 8, 2009. The record is absent an
23 explanation as to why these medications were refilled only two weeks after the August 26, 2009
24 prescriptions were written when the August 26, 2009 prescriptions were written for a 30 day
25 supply of medications.

26 e. R.J. presented to Respondent on October 7, 2009 with complaints of low back
27 pain. Respondent refilled the prescriptions for OxyContin and Percocet at the same levels and

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1 increased the Xanax prescription from 60 to 90 tablets and prescribed a new medication, Adderall
2 20 mg quantity 30. The records are absent an explanation for the increased quantity of Xanax.

3 f. R.J. presented to Respondent on November 9, 2009 to discuss x-ray findings
4 though there is no x-ray report in R.J.'s chart. Respondent recommended a lumbar MRI.

5 g. On January 10, 2011, R.J. was seen by Respondent for complaints of right
6 shoulder and low back pain. Respondent recommended that R.J. attend a support group in his
7 office. Respondent refilled R.J.'s medications, increasing the quantity of the Adderall
8 prescription from 60 tablets to 90 tablets and continuing to prescribe oxycodone quantity 90,
9 Norco quantity 90 and Xanax quantity 60.

10 h. On February 10, 2011, R.J. was seen by Respondent with complaints that his
11 symptoms had worsened and that he begun taking six oxycodone daily instead of three
12 oxycodone and three Norco. R.J.'s chart reflects that his pain intensity was 2 to 4 with
13 medication and 9 to 10 without medication. Respondent's primary diagnosis was lumbar facet
14 syndrome. Respondent's plan was to refill R.J.'s medication and he instructed R.J. to continue
15 chiropractic care and physical therapy on his own. Respondent increased R.J.'s prescriptions for
16 oxycodone to 120 tablets, Norco to 120 tablets, and Xanax to 90 tablets. Respondent also refilled
17 R.J.'s Adderall at 90 tablets that day to 120 tablets. No reason is noted in the chart for the
18 increased dosages of the medications.

19 i. R.J. presented to Respondent on March 3, 2011, 21 days after his last visit and
20 Respondent refilled R.J.'s oxycodone, Norco, Xanax and Adderall at the same quantities even
21 though the prescriptions from February had been for a 30 day supply of drugs. R.J.'s chart
22 reflects that R.J. was going out of town for two weeks so he presented early for a refill of his
23 medications. Thereafter, R.J. should have been kept on his original medication schedule with
24 refills being due on approximately April 8, 2011; however, Respondent refilled R.J.'s
25 medications early on March 30, 2011. The March 3, 2011 note also sets forth a notation of
26 "DUI" in the pain history section. At the time of his Medical Board Interview, Respondent
27 indicated that he did not know the meaning of "DUI" in the note.

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1 j. R.J. was seen by Respondent on May 16, 2011. The pain history section of the
2 notation is illegible. It is noted that at the time of this visit, Respondent recommended reducing
3 R.J.'s medications but prescribed the same quantity of oxycodone, Norco and Adderall. He
4 substituted Soma 350 mg quantity 90 for Xanax without explanation for the change.

5 k. R.J. was seen by Respondent on June 22, 2011, at which time Respondent notes
6 that R.J. is out of medications. Respondent issued prescriptions for oxycodone, Norco, Soma,
7 and Adderall in the quantities previously prescribed.

8 l. On July 20, 2011, R.J. presented to Respondent with complaints of pain in the
9 right shoulder and low back. Respondent switched R.J.'s prescription of Soma back to Xanax
10 and the notation regarding Xanax in the plan section is illegible. In addition to prescribing
11 Xanax, Respondent prescribed Adderall, oxycodone and Norco. While the office visit note
12 reflects the date of July 20, 2011, the prescriptions are dated July 19, 2011:

13 m. On August 16, 2011, R.J. presented to Respondent and reported that his
14 medications had been stolen from his medicine cabinet and he had been without medications for
15 one week. Respondent recommended that R.J. reduce his medications but refilled R.J.'s
16 medications at the same quantities previously prescribed. This was R.J.'s last noted visit to
17 Respondent's office.

18 n. Respondent was negligent in failing to provide proper oversight in monitoring
19 R.J.'s use of controlled substances.

20 **FIRST CAUSE FOR DISCIPLINE**
21 **(Gross Negligence-Patient T.S.)**

22 19. Respondent is subject to disciplinary action under Code Section 2234, subdivision
23 (b), in that he engaged in gross negligence in the treatment of patient T.S. Paragraph 15 is
24 incorporated herein by reference as if fully set forth herein. The circumstances are as follows:

25 20. Respondent was grossly negligent and violated Code section 2234, subdivision (b),
26 when he failed to comply with the standard of care for prescribing controlled substances to T.S.,
27 in that, Respondent failed to:

28 a. Appropriately prescribe controlled substances for chronic pain conditions;

- 1 d. Establish medical indications for the use of opioids;
- 2 e. Justify the need for controlled substances;
- 3 f. Establish a treatment plan and objectives for the use of opioids;
- 4 g. Periodically review the course of pain treatment and make appropriate
- 5 modifications in treatment based on T.S.'s progress or lack of progress;
- 6 h. Obtain additional evaluations and consultations from other physicians, as
- 7 required, when dealing with complex medical pain problems;
- 8 i. Review information pertaining to the use of controlled substances, including
- 9 CURES reports on a periodic basis; and
- 10 j. Make further inquiry over the course of treatment when urine screens showed
- 11 significant discrepancies and inconsistencies were discovered.

12 **Patient J.C.**

13 23. Respondent engaged in repeated acts of negligence and violated Code section 2234,

14 subdivision (c), when he failed to comply with the standard of care for prescribing controlled

15 substances to J.C., in that, Respondent failed to:

- 16 a. Appropriately prescribe controlled substances for chronic pain conditions;
- 17 b. Obtain a full substance abuse history;
- 18 c. Discuss the risks and benefits of the use of controlled substances along with
- 19 other treatment modalities;
- 20 d. Justify the need for controlled substances;
- 21 e. Periodically review the course of pain treatment and make appropriate
- 22 modifications in treatment based on J.C.'s progress or lack of progress;
- 23 f. Require a urine report before prescribing controlled substances;
- 24 g. Issued prescriptions for multiple sedatives, including two benzodiazepines,
- 25 Soma and increased her opioid prescriptions;
- 26 h. Document the need for both Valium and Xanax prescriptions;
- 27 i. Changed J.C.'s prescriptions from 30 mg of hydrocodone per day to 120 mg of
- 28 morphine per day without an explanation in the record; and

1 j. Discuss or document J.C.'s falling incident in relation to her medical regimen.

2 **Patient K.D.**

3 24. Respondent engaged in repeated acts of negligence and violated Code section 2234,
4 subdivision (c), when he failed to comply with the standard of care for performing epidural
5 injections on K.D., as follows:

6 a. Respondent failed to obtain or review spinal imaging prior to performing
7 epidural injections on K.D. in order to come to a definitive diagnosis and more precisely target
8 the source of pain prior to performing the procedure

9 b. Respondent administered steroid injections to K.D. in excess. From December
10 2007 through December 2008, Respondent administered steroid injections a total of ten (10)
11 times. Further, on several occasions, he administered multiple doses of steroids on the same day
12 to different anatomic locations.

13 c. Respondent arbitrarily performed a series of epidural injections without interval
14 assessment of treatment efficacy. There is no documentation of interval patient
15 assessment of K.D. between procedures and there is no documentation of assessment of treatment
16 efficacy for the injections performed.

17 **Patient R.J.**

18 25. Respondent engaged in repeated acts of negligence and violated Code section 2234,
19 subdivision (c), when he failed to comply with the standard of care for prescribing controlled
20 substances to R.J., in that, Respondent failed to provide proper oversight in monitoring R.J.'s use
21 of controlled substances.

22 **THIRD CAUSE FOR DISCIPLINE**

23 **(Excessive Administration of Drugs or Treatment – Patient K.D.)**

24 26. Respondent is subject to disciplinary action under section 725 of the Code in that he
25 excessively administered drugs or treatment to K.D. Paragraphs 17 and 24 above are
26 incorporated herein by reference as if fully set forth herein. The circumstances are as follows:

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1 27. Respondent excessively administered drugs or treatment to K.D. and violated Code
2 section 725, when he failed to comply with the standard of care for performing epidural
3 injections, as follows:

4 a. Respondent administered steroid injections to K.D. in excess. On several
5 occasions, he administered multiple doses of steroids on the same day to different anatomic
6 locations.

7 b. Respondent arbitrarily performed a series of epidural injections without interval
8 assessment of treatment efficacy. There is no documentation of interval patient assessment of
9 K.D. between procedures and there is no documentation of assessment of treatment efficacy for
10 the injections performed.

11 **FOURTH CAUSE FOR DISCIPLINE**
12 **(Failure to Maintain Adequate and Accurate Records – Patients T.S., J.C., K.D. and R.J.)**

13 28. By reason of the facts set forth above in the First and Second Causes for Discipline,
14 Respondent is subject to disciplinary action under Code Section 2266 for failure to maintain
15 adequate and accurate medical records. Paragraphs 15 through 27 above are incorporated herein
16 by reference as if fully set forth herein.

17 29. Respondent is subject to disciplinary action under Code Section 2266 in that
18 Respondent made errors in prescribed medications listed on submitted forms in relation to the
19 urine tests for patient T.S., and all of Respondent's follow-up reports are hand written on
20 preprinted forms and circled words on the form do not indicate positive or negative findings.

21 30. Respondent is subject to disciplinary action under Code Section 2266 in that some of
22 the handwritten reports for T.S. are signed by both M.S., D.C. and J. Petraglia, M.D., and it
23 cannot be determined which provider was documenting findings and making recommendations.

24 31. Respondent is subject to disciplinary action under Code Section 2266 in that his
25 treatment plan and objectives for J.C. did not meet Medical Board guideline requirements that the
26 records contain stated objectives, and all of Respondent's follow-up reports are hand-written on
27 preprinted forms and circled words on the form do not indicate positive or negative findings.

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1 medically appropriate recommendation or approval for the possession or cultivation of marijuana
2 for the personal medical purposes of the patient within the meaning of Health and Safety Code
3 section 11362.5. In addition, Respondent shall inform the patient or the patient's primary
4 caregiver that Respondent is prohibited from issuing a recommendation or approval for the
5 possession or cultivation of marijuana for the personal medical purposes of the patient and that
6 the patient or the patient's primary caregiver may not rely on Respondent's statements to legally
7 possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall
8 fully document in the patient's chart that the patient or the patient's primary caregiver was so
9 informed. Nothing in this condition prohibits Respondent from providing the patient or the
10 patient's primary caregiver information about the possible medical benefits resulting from the use
11 of marijuana."

12 "..."

13 36. Respondent's probation is subject to revocation because he failed to comply with
14 Condition (1) of the August 22, 2013, Decision, referenced above. The facts and circumstances
15 regarding this violation are as follows:

16 37. In or about June 2013, Respondent hired Nurse Practitioner, T.G., to see patients at
17 Interventional Pain Medical Group, Respondent's medical office in Fresno, generally working
18 every Thursday and rarely, but on occasion, Wednesdays and Fridays. T.G. worked for a
19 different medical practice in Fresno on Mondays, Tuesdays and Wednesdays. T.G. travelled to
20 Respondent's office in Newport Beach infrequently.

21 38. T.G. had her own DEA license and was permitted to prescribe Schedule II and III
22 controlled substances.

23 39. Despite the August 22, 2013, Decision, becoming effective on September 20, 2013,
24 Respondent continued to prescribe Schedule II and III controlled substances, using T.G.'s
25 prescription pads.

26 40. T.H., a medical assistant then employed in Respondent's Fresno office, observed that
27 on days T.G. was absent from the office, the patients were evaluated by Respondent and given
28 prescriptions for controlled substances that were written on T.G.'s prescription pad, as follows:

1 a. T.G. did not work in Respondent's Fresno office on Wednesday, February 26,
2 2014.

3 1. On February 26, 2014, patient B.P. was issued the following prescriptions
4 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/325
5 mg (200 tablets);¹⁸ OxyContin 40 mg (60 tablets);¹⁹ and Ambien 10 mg (30 tablets).

6 b. T.G. did not work in Respondent's Fresno office on Thursday, February 27,
7 2014.

8 1. On February 27, 2014, patient K.J. was issued the following prescriptions
9 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/325
10 mg (180 tablets); Opana IR 10 mg (90 tablets);²⁰ and, Opana ER 30 mg (60 tablets).²¹

11 2. On February 27, 2014, patient W.C. was issued the following
12 prescriptions on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno:
13 Norco 10 mg/325 mg (180 tablets); morphine sulfate ER 60 mg (60 tablets);²² and Restoril 30 mg
14 (30 capsules).

15 c. T.G. did not work in Respondent's Fresno office on Wednesday, March 5,
16 2014.

17 1. On March 5, 2014, patient R.M. was issued the following prescriptions on
18 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10mg/325 mg
19 (90 tablets); flexeril 10 mg (90 tablets); and Nucynta ER 150 mg (60 tablets).²³

20 d. T.G. did not work in Respondent's Fresno office on Thursday, March 6, 2014.

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22 ¹⁸ Norco is a Schedule II Controlled Substance.

23 ¹⁹ OxyContin is a Schedule II Controlled Substance.

24 ²⁰ Opana IR is a Schedule II Controlled Substance.

25 ²¹ Opana ER is a Schedule II Controlled Substance.

26 ²² Morphine Sulfate ER is a Schedule II Controlled Substance.

27 ²³ Nucynta ER is a Schedule II Controlled Substance.

1 1. On March 6, 2014, patient S.P. was issued the following prescriptions on
2 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: morphine sulfate IR
3 30 mg (90 tablets);²⁴ morphine sulfate ER-60 mg (60 tablets); and flexeril 10 mg (90 tablets).

4 2. On March 6, 2014, patient E.M. was issued the following prescriptions on
5 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: OxyContin 80 mg (90
6 tablets); Roxicodone 30 mg (150 tablets);²⁵ and tizanidine 4 mg (40 tablets).

7 e. T.G. did not work in Respondent's Fresno office on Wednesday March 12,
8 2014.

9 1. On March 12, 2014, patient E.A. was issued the following prescription on
10 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: hydrocodone-
11 acetaminophen 10mg/325 mg (180 tablets).²⁶

12 2. On March 12, 2014, patient L.H. was issued the following prescriptions
13 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Opana ER 40 mg
14 (90 tablets) and Norco 10 mg/350 mg (180 tablets).

15 3. On March 12, 2014, patient R.R. was issued the following prescriptions
16 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/350
17 mg (150 tablets); klonopin 1 mg (30 tablets); and baclofen 10 mg (60 tablets).

18 f. T.G. did not work in Respondent's Fresno office on Thursday, March 13, 2014.

19 1. On March 13, 2014, patient L.O. was issued the following prescription on
20 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/350 mg
21 (60 tablets).

22 2. On March 13, 2014, patient B.S. was issued the following prescriptions
23 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/350
24 mg (180 tablets) and Roxicodone 30 mg (120 tablets).

25
26 ²⁴ Morphine Sulfate IR is a Schedule II Controlled Substance.

27 ²⁵ Roxicodone is a Schedule II Controlled Substance.

28 ²⁶ Hydrocodone-acetaminophen is a Schedule II Controlled Substance.

1 g. T.G. did not work in Respondent's Fresno office on Thursday, May 15, 2014.

2 1. On May 15, 2014, patient L.W. was issued the following prescription on
3 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: morphine sulfate ER
4 60 mg (30 tablets); Cymbalta (90 tablets); and docusate (60 capsules).

5 2. On May 15, 2014, patient E.A. was issued the following prescription on
6 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: hydrocodone-
7 acetaminophen 10mg/325 mg (150 tablets).

8 3. On May 15, 2014, patient R.S. was issued the following prescription on
9 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: hydrocodone-
10 acetaminophen 10mg/325 mg (120 tablets).

11 h. T.G. did not work in Respondent's Fresno office on Thursday, July 17, 2014.

12 1. On July 17, 2014, patient C.A. was issued the following prescription on
13 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: morphine sulfate ER
14 60 mg (90 tablets); Baclofen 20 mg (90 tablets); and Elavil 25 mg (30 tablets).

15 2. On July 17, 2014, patient T.C. was issued the following prescription on
16 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/325 mg
17 (120 tablets); flexeril 10 mg (60 tablets) and ibuprofen 800 mg (60 tablets).

18 i. T.G. did not work in Respondent's Fresno office on Thursday, July 31, 2014.

19 1. On July 31, 2014, patient S.T. was issued the following prescription on
20 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: amrix 15 mg (50
21 capsules); Xanax 0.5 mg (60 tablets); and Norco 10mg/325 mg (60 tablets).

22 2. On July 31, 2014, patient L.S. was issued the following prescription on
23 T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: hydrocodone-
24 acetaminophen 5 mg/325 mg (30 tablets) and Cymbalta 30 mg (30 capsules).

25 j. T.G. did not work in Respondent's Fresno office on Thursday, August 14,
26 2014.

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1 1. On August 14, 2014, patient M.C. was issued the following prescriptions
2 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: hydrocodone-
3 acetaminophen 10 mg/325 mg (60 tablets) and ibuprofen 600 mg (60 tablets).

4 k. T.G. did not work in Respondent's Fresno office on Wednesday, August 20,
5 2014.

6 1. On August 20, 2014, patient K.A. was issued the following prescription
7 by T.G. in Newport Beach: hydrocodone-acetaminophen 10 mg/325 mg (150 tablets).

8 2. On August 20, 2014, patient E.A. was issued the following prescriptions
9 on T.G.'s prescription pad from Interventional Pain Medical Group in Fresno: Norco 10 mg/325
10 mg (120 tablets) and naproxen 500 mg (60 tablets).

11 41. Patient K.A. was a patient in Respondent's Newport Beach office in 2014. When she
12 presented to Respondent's office, patient K.A. would be seen and evaluated by Respondent or
13 chiropractor, Dr. M.S., who was also employed by Respondent. On February 25, 2014,
14 September 17, 2014, October 8, 2014 and November 26, 2014, patient K.A. was issued
15 prescriptions for Norco on T.G.'s prescription pad from Interventional Pain Medical Group in
16 Newport Beach. Patient K.A. received each of these prescriptions at the front desk followed by
17 her evaluation by either Respondent or Dr. M.S. Patient K.A. has never been seen or evaluated
18 by T.G. in Respondent's office.

19 42. Patient K.D. was a patient in Respondent's Newport Beach office in 2014. When she
20 presented to Respondent's office, patient K.D. would be taken to an examination room and have
21 her vital signs taken by Respondent's receptionist and medical assistant A.S. or another female
22 medical assistant who worked for Respondent. Thereafter, patient K.D. would be seen and
23 evaluated by Respondent or chiropractor, Dr. M.S., who was also employed by Respondent. On
24 May 12, 2014, June 10, 2014, July 9, 2014, August 7, 2014 and September 4, 2014, patient K.D.
25 was issued prescriptions for OxyContin and morphine sulfate ER on T.G.'s prescription pad from
26 Interventional Pain Medical Group in Newport Beach. Patient K.D. received each of these
27 prescriptions at the front desk followed by her evaluation by either Respondent or Dr. M.S.
28 Patient K.D. has never been seen or evaluated by T.G. in Respondent's office.

SECOND CAUSE TO REVOKE PROBATION
(Failure to Comply: Quarterly Declarations)

43. Condition (11) of the August 22, 2013, Decision and Order states:

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

"..."

44. Respondent's probation is subject to revocation because he failed to comply with Condition (11) of the August 22, 2013, Decision, referenced above. The facts and circumstances regarding this violation are as follows:

45. On September 19, 2013, Respondent executed his Quarterly Declaration Due Date Statement indicating that he understands that "[f]ailure to comply with the [quarterly declarations] reporting requirements is a **violation of probation and is grounds for administrative action to revoke probation** and carry out the Decision that was stayed." [emphasis in original].

46. On October 1, 2013, Respondent executed his Quarterly Declaration for the reporting period of July-September 2013, indicating that his primary place of practice is 1601 Dove Street, Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach as the other location where he practices medicine.

47. On January 1, 2013, Respondent executed his Quarterly Declaration for the reporting period of October-December 2013, indicating that his primary place of practice is 1601 Dove Street, Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach as the other location where he practices medicine.²⁷

48. On April 3, 2014, Respondent executed his Quarterly Declaration for the reporting period of January-March 2014, indicating that his primary place of practice is 1601 Dove Street, Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach as the other location where he practices medicine.

///

²⁷ It appears that the date of execution, January 1, 2013, should have been 2014, as this Quarterly Report was received by the Medical Board of California on January 13, 2014.

1 49. On July 7, 2014, Respondent executed his Quarterly Declaration for the reporting
2 period of April-June 2014, indicating that his primary place of practice is 1601 Dove Street, Suite
3 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach and
4 Placentia Linda Hospital in Placentia as other locations where he practices medicine.

5 50. On October 5, 2014, Respondent executed his Quarterly Declaration for the reporting
6 period of July-September 2014, indicating that his primary place of practice is 1601 Dove Street,
7 Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach
8 and Placentia Linda Hospital in Placentia as other locations where he practices medicine.

9 51. On January 5, 2015, Respondent executed his Quarterly Declaration for the reporting
10 period of October-December, 2014, indicating that his primary place of practice is 1601 Dove
11 Street, Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long
12 Beach and Placentia Linda Hospital as other locations where he practices medicine.

13 52. On March 30, 2015, Respondent executed his Quarterly Declaration for the reporting
14 period of January-March 2015, indicating that his primary place of practice is 1601 Dove Street,
15 Suite 170, Newport Beach, California 92660. He also listed Community Hospital of Long Beach
16 and Placentia Linda Hospital in Placentia as other locations where he practices medicine.

17 53. On April 21, 2015, Respondent met with his Probation Inspector M.J. at which time
18 M.J. asked Respondent if there were any changes to his previously submitted quarterly
19 declaration. Respondent stated everything was the same but that he occasionally sees patients in
20 Fresno and misunderstood the question in his Quarterly Declaration that requests that he state any
21 location where he practices medicine. Probation Inspector M.J. sets forth the following in her
22 April 29, 2015 Report:

23 "On 4/21/15, I met with [Respondent] at his office, located at 1601 Dove St. #170,
24 Newport Beach, CA. I handed [Respondent] his previously submitted quarterly
25 declaration and asked him if there were any changes. He stated that everything
26 was the same. I then asked him if he still practiced at the locations listed in his
27 quarterly declaration, (1601 Dove Street, Newport Beach, CA and Community
28 Hospital of Long Beach, CA and Placentia Linda Hospital, Placentia, CA). He
stated, 'Yes.' He then paused for a second and stated that he occasionally goes to
Fresno and sees patients. I asked him why he had not indicated or provided that
information in his previous quarterly declarations. He stated that the Fresno office

1 is not his primary practice. He thought that he did not have to report that. He
2 stated that he has been referring all his patients from Fresno to other physicians
3 and only goes once every two weeks for injections or referrals. I asked
4 [Respondent] to read out loud the question from the quarterly declaration. He read
5 it and said that he misunderstood the question. I advised him that he needs to
6 indicate all places where he practices, even for an injection or referral..."

7 54. On July 1, 2015, Respondent executed his Quarterly Declaration for the reporting
8 period of April-June 2015, indicating that his primary place of practice is 1601 Dove Street, Suite
9 170, Newport Beach, California 92663 [sic] and 6210 North First Street, Fresno, California
10 93710. He also listed Community Hospital of Long Beach, 6210 North First Street in Fresno and
11 Placentia Linda Hospital as other locations where he practices medicine.

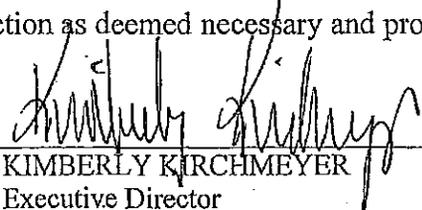
12 55. While Respondent maintained a medical office at 6210 North First Street, Fresno,
13 California 93710 prior to October 1, 2013 and continuing through July 1, 2015, he failed to list
14 the Fresno address as a location where he practices medicine on his Quarterly Declarations until
15 July 1, 2015.

16 **PRAYER**

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

- 19 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 68169,
20 issued to John F. Petraglia, M.D.;
- 21 2. Revoking, suspending or denying approval of his authority to supervise physician
22 assistants pursuant to section 3527 of the Code;
- 23 3. Ordering him to pay, if placed on probation, the costs of probation monitoring;
- 24 4. Denying his authority to employ nurse practitioners; and
- 25 5. Taking such other and further action as deemed necessary and proper.

26 DATED: November 13, 2015

27 
KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

28 *Complainant*

LA2013610890

Exhibit A

DECISION, Case No. 04-2011-219449

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

In the Matter of the Second Amended)
Accusation Against:)

JOHN F. PETRAGLIA, M.D.)

Case No. 04-2011-219449

Physician's and Surgeon's)
Certificate No. G-68169)

Respondent)
_____)

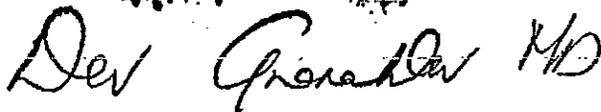
DECISION

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

This Decision shall become effective at 5:00 p.m. on September 20, 2013.

IT IS SO ORDERED: August 22, 2013.

MEDICAL BOARD OF CALIFORNIA



Dev Gnanadev, M.D., Vice-Chair
Panel B

1 KAMALA D. HARRIS
Attorney General of California
2 E. A. JONES III
Senior Assistant Attorney General
3 EDWARD KIM
Deputy Attorney General
4 State Bar No. 195729
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 897-7336
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

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

11 In the Matter of the Second Amended
12 Accusation Against:

13 **JOHN F. PETRAGLIA**
14 1601 Dove Street, Suite 170
Newport Beach, CA 92660

15 **Physician's and Surgeon's**
16 **Certificate No. G 68169**

16 Respondent.

Case No. 04-2011-219449

OAH No. 2012110551

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

20 PARTIES

21 1. Kimberly Kirchmeyer (Complainant) is the Interim Executive Director of the Medical
22 Board of California, Department of Consumer Affairs ("Board"). The former Executive Director
23 brought this action solely in her official capacity. Complainant is represented in this matter by
24 Kamala D. Harris, Attorney General of the State of California, by Edward Kim, Deputy Attorney
25 General.

26 2. Respondent John F. Petraglia (Respondent) is represented in this proceeding by
27 attorney Raymond J. McMahon, whose address is: 1851 E. First Street, Suite 810, Santa Ana, CA
28 92705-4041.

1 Respondent does not contest that, at an administrative hearing, Complainant could establish a
2 prima facie case with respect to the remaining charges and allegations contained in Second
3 Amended Accusation No. 04-2011-219449 and that he has thereby subjected his license to
4 disciplinary action.

5 10. Respondent agrees that if he ever petitions for early termination or modification of
6 probation, or if the Board ever petitions for revocation of probation, all of the charges and
7 allegations contained in Accusation No. 04-2011-219449 shall be deemed true, correct and fully
8 admitted by respondent for purposes of that proceeding or any other licensing proceeding
9 involving respondent in the State of California.”

10 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
11 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
12 Disciplinary Order below.

13 CONTINGENCY

14 12. This stipulation shall be subject to approval by the Medical Board of California.
15 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
16 Board of California may communicate directly with the Board regarding this stipulation and
17 settlement, without notice to or participation by Respondent or his counsel. By signing the
18 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
19 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
20 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
21 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
22 action between the parties, and the Board shall not be disqualified from further action by having
23 considered this matter.

24 13. The parties understand and agree that facsimile copies of this Stipulated Settlement
25 and Disciplinary Order, including facsimile signatures thereto, shall have the same force and
26 effect as the originals.

27 14. In consideration of the foregoing admissions and stipulations, the parties agree that
28 the Board may, without further notice or formal proceeding, issue and enter the following

1 Disciplinary Order:

2 **DISCIPLINARY ORDER**

3 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 68169 issued
4 to John F. Petraglia (Respondent) is revoked. However, the revocation is stayed and Respondent
5 is placed on probation for seven (7) years on the following terms and conditions.

6 1. **CONTROLLED SUBSTANCES - PARTIAL RESTRICTION.** Respondent shall not
7 order, prescribe, dispense, administer, furnish, or possess any Schedule II or Schedule III
8 controlled substances as defined by the California Uniform Controlled Substances Act, except in
9 the perioperative setting when Respondent is acting as anesthesiologist for a patient where the
10 patient will only use such controlled substances at the location of the procedure (i.e., the
11 foregoing exception shall not apply to any controlled substances that are used outside of such
12 perioperative setting). Respondent shall not issue an oral or written recommendation or approval
13 to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the
14 personal medical purposes of the patient within the meaning of Health and Safety Code section
15 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and
16 medical indication, that a patient's medical condition may benefit from the use of marijuana,
17 Respondent shall so inform the patient and shall refer the patient to another physician who,
18 following an appropriate prior examination and medical indication, may independently issue a
19 medically appropriate recommendation or approval for the possession or cultivation of marijuana
20 for the personal medical purposes of the patient within the meaning of Health and Safety Code
21 section 11362.5. In addition, Respondent shall inform the patient or the patient's primary
22 caregiver that Respondent is prohibited from issuing a recommendation or approval for the
23 possession or cultivation of marijuana for the personal medical purposes of the patient and that
24 the patient or the patient's primary caregiver may not rely on Respondent's statements to legally
25 possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall
26 fully document in the patient's chart that the patient or the patient's primary caregiver was so
27 informed. Nothing in this condition prohibits Respondent from providing the patient or the
28 patient's primary caregiver information about the possible medical benefits resulting from the use

1 of marijuana.

2 Throughout his term of probation, Respondent shall provide to his practice monitor, as
3 described below: (a) copies of all records of controlled substances ordered, prescribed, dispensed,
4 administered, or possessed by Respondent (collectively, the "CS Records"); and (b) copies of his
5 anesthesia records, including drug logs, for each patient that he provides care to in the
6 perioperative setting (collectively, the "Anesthesia Records").

7 2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO
8 RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled
9 substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any
10 recommendation or approval which enables a patient or patient's primary caregiver to possess or
11 cultivate marijuana for the personal medical purposes of the patient within the meaning of Health
12 and Safety Code section 11362.5, during probation, showing all the following: 1) the name and
13 address of patient; 2) the date; 3) the character and quantity of controlled substances involved;
14 and 4) the indications and diagnosis for which the controlled substances were furnished.

15 Respondent shall keep these records in a separate file or ledger, in chronological order. All
16 records and any inventories of controlled substances shall be available for immediate inspection
17 and copying on the premises by the Board or its designee at all times during business hours and
18 shall be retained for the entire term of probation.

19 3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
20 date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the
21 Prescribing Practices Course at the Physician Assessment and Clinical Education Program,
22 University of California, San Diego School of Medicine (Program), approved in advance by the
23 Board or its designee. Respondent shall provide the program with any information and documents
24 that the Program may deem pertinent. Respondent shall participate in and successfully complete
25 the classroom component of the course not later than six (6) months after Respondent's initial
26 enrollment. Respondent shall successfully complete any other component of the course within
27 one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense
28 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of

1 licensure.

2 A prescribing practices course taken after the acts that gave rise to the charges in the
3 Second Amended Accusation, but prior to the effective date of the Decision may, in the sole
4 discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the
5 course would have been approved by the Board or its designee had the course been taken after the
6 effective date of this Decision.

7 Respondent shall submit a certification of successful completion to the Board or its
8 designee not later than 15 calendar days after successfully completing the course, or not later than
9 15 calendar days after the effective date of the Decision, whichever is later.

10 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
11 date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to
12 the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education
13 Program, University of California, San Diego School of Medicine (Program), approved in
14 advance by the Board or its designee. Respondent shall provide the program with any information
15 and documents that the Program may deem pertinent. Respondent shall participate in and
16 successfully complete the classroom component of the course not later than six (6) months after
17 Respondent's initial enrollment. Respondent shall successfully complete any other component of
18 the course within one (1) year of enrollment. The medical record keeping course shall be at
19 Respondent's expense and shall be in addition to the Continuing Medical Education (CME)
20 requirements for renewal of licensure.

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

26 Respondent shall submit a certification of successful completion to the Board or its
27 designee not later than 15 calendar days after successfully completing the course, or not later than
28 15 calendar days after the effective date of the Decision, whichever is later.

1 5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
2 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
3 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.
4 Respondent shall participate in and successfully complete that program. Respondent shall
5 provide any information and documents that the program may deem pertinent. Respondent shall
6 successfully complete the classroom component of the program not later than six (6) months after
7 Respondent's initial enrollment, and the longitudinal component of the program not later than the
8 time specified by the program, but no later than one (1) year after attending the classroom
9 component. The professionalism program shall be at Respondent's expense and shall be in
10 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

19 6. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date
20 of this Decision, Respondent shall enroll in a clinical training or educational program equivalent
21 to the Physician Assessment and Clinical Education Program (PACE) offered at the University of
22 California - San Diego School of Medicine ("Program"). Respondent shall successfully complete
23 the Program not later than six (6) months after Respondent's initial enrollment unless the Board
24 or its designee agrees in writing to an extension of that time.

25 The Program shall consist of a Comprehensive Assessment program comprised of a two-
26 day assessment of Respondent's physical and mental health; basic clinical and communication
27 skills common to all clinicians; and medical knowledge, skill and judgment pertaining to
28 Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum,

1 a 40 hour program of clinical education in the area of practice in which Respondent was alleged
2 to be deficient and which takes into account data obtained from the assessment, Decision(s),
3 Accusation(s), and any other information that the Board or its designee deems relevant.

4 Respondent shall pay all expenses associated with the clinical training program.

5 Based on Respondent's performance and test results in the assessment and clinical
6 education, the Program will advise the Board or its designee of its recommendation(s) for the
7 scope and length of any additional educational or clinical training, treatment for any medical
8 condition, treatment for any psychological condition, or anything else affecting Respondent's
9 practice of medicine. Respondent shall comply with Program recommendations.

10 At the completion of any additional educational or clinical training, Respondent shall
11 submit to and pass an examination. Determination as to whether Respondent successfully
12 completed the examination or successfully completed the program is solely within the program's
13 jurisdiction.

14 If Respondent fails to enroll, participate in, or successfully complete the clinical training
15 program within the designated time period, Respondent shall receive a notification from the
16 Board or its designee to cease the practice of medicine within three (3) calendar days after being
17 so notified. The Respondent shall not resume the practice of medicine until enrollment or
18 participation in the outstanding portions of the clinical training program have been completed. If
19 the Respondent did not successfully complete the clinical training program, the Respondent shall
20 not resume the practice of medicine until a final decision has been rendered on the Second
21 Amended Accusation and/or a petition to revoke probation. The cessation of practice shall not
22 apply to the reduction of the probationary time period.

23 7. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective
24 date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a
25 practice monitor and a billing monitor, the name and qualifications of one or more licensed
26 physicians and surgeons whose licenses are valid and in good standing, and who are preferably
27 American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or
28 current business or personal relationship with Respondent, or other relationship that could

1 reasonably be expected to compromise the ability of the monitor to render fair and unbiased
2 reports to the Board, including but not limited to any form of bartering, shall be in Respondent's
3 field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all
4 monitoring costs.

5 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
6 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
7 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
8 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
9 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
10 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
11 signed statement for approval by the Board or its designee.

12 Within 60 calendar days of the effective date of this Decision, and continuing throughout
13 probation, Respondent's practice and billing for anesthesia shall be monitored by the approved
14 monitor. Respondent shall make all records available for immediate inspection and copying on
15 the premises by the monitor at all times during business hours and shall retain the records for the
16 entire term of probation. Throughout his term of probation, Respondent shall provide to his
17 practice monitor, copies of all of his CS Records (as defined in Section 1 above) and Anesthesia
18 Records, no later than 10 calendar days after the end of each month. The practice monitor will
19 review the CS Records, Anesthesia Records, and any other documents provided by the Board and
20 report to the Board (within 10 calendar days of receipt of any report) when Respondent's
21 practices with respect to the CS Records fall below the standards of practice of medicine.
22 Throughout his term of probation, Respondent shall provide to his billing monitor, copies of all of
23 his Anesthesia Records, no later than 10 calendar days after the end of each month.

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

1 The monitor(s) shall submit a quarterly written report to the Board or its designee which
2 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
3 are within the standards of practice of medicine and billing for anesthesia, and whether
4 Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole
5 responsibility of Respondent to ensure that the monitor submits the quarterly written reports to
6 the Board or its designee within 10 calendar days after the end of the preceding quarter and that
7 the monitor submits all other required reports within the specified time period.

8 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
9 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
10 name and qualifications of a replacement monitor who will be assuming that responsibility within
11 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
12 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
13 notification from the Board or its designee to cease the practice of medicine within three (3)
14 calendar days after being so notified Respondent shall cease the practice of medicine until a
15 replacement monitor is approved and assumes monitoring responsibility.

16 In lieu of a monitor, Respondent may participate in a professional enhancement program
17 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the
18 University of California, San Diego School of Medicine, that includes, at minimum, quarterly
19 chart review, semi-annual practice assessment, and semi-annual review of professional growth
20 and education. Respondent shall participate in the professional enhancement program at
21 Respondent's expense during the term of probation.

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

1 15 calendar days.

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

3 9. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is
4 prohibited from supervising physician assistants.

5 10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules
6 governing the practice of medicine in California and remain in full compliance with any court
7 ordered criminal probation, payments, and other orders.

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

11 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
12 of the preceding quarter.

13 12. GENERAL PROBATION REQUIREMENTS.

14 Compliance with Probation Unit

15 Respondent shall comply with the Board's probation unit and all terms and conditions of
16 this Decision.

17 Address Changes

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

23 Place of Practice

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

27 License Renewal

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

1 license.

2 Travel or Residence Outside California

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

6 In the event Respondent should leave the State of California to reside or to practice
7 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
8 departure and return.

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

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

23 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
24 months, Respondent shall successfully complete a clinical training program that meets the criteria
25 of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and
26 Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

1 Periods of non-practice will relieve Respondent of the responsibility to comply with the
2 probationary terms and conditions with the exception of this condition and the following terms
3 and conditions of probation: Obey All Laws; and General Probation Requirements.

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

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

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

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

1 year.

2 ACCEPTANCE

3 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
4 discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect
5 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement
6 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
7 Decision and Order of the Medical Board of California.

8
9 DATED: 6-24-13
10 _____
11 JOHN F. PETRAGLIA
12 Respondent

13 I have read and fully discussed with Respondent John F. Petraglia the terms and conditions
14 and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve
15 its form and content.

16 DATED: June 24, 2013
17 _____
18 RAYMOND J. MCMAHON
19 Attorney for Respondent

20 ENDORSEMENT

21 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
22 submitted for consideration by the Medical Board of California of the Department of Consumer

23 Affairs.
24 Dated:

25 Respectfully submitted,
26 KAMALA D. HARRIS
27 Attorney General of California
28 E. A. JONES III
Senior Assistant Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

JOHN F. PETRAGLIA
Respondent

I have read and fully discussed with Respondent John F. Petraglia the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

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

Dated: 6/25/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Senior Assistant Attorney General



EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 04-2011-219449

1 KAMALA D. HARRIS
Attorney General of California
2 GLORIA L. CASTRO
Supervising Deputy Attorney General
3 EDWARD KIM
Deputy Attorney General
4 State Bar No. 195729
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7 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO February 14 20 13
BY H. Park ANALYST

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

11 In the Matter of the Second Amended
Accusation Against:
12 **JOHN PETRAGLIA, M.D.**
13 1601 Dove Street, Suite 170
Newport Beach, CA 92660
14 Physician's and Surgeon's Certificate
15 No. G68169,
16 Respondent.

OAH No. 2012110551
Case No. 04-2011-219449
SECOND AMENDED
ACCUSATION

18 Complainant alleges:

19 **PARTIES**

- 20 1. Linda K. Whitney (Complainant) brings this Second Amended Accusation solely in
21 her official capacity as the Executive Director of the Medical Board of California.
22 2. On or about March 12, 1990, the Medical Board of California, Department of
23 Consumer Affairs, issued Physician's and Surgeon's Certificate Number G68169 to John
24 Petraglia, M.D. (Respondent). That Certificate was in full force and effect at all times relevant to
25 the charges brought herein and will expire on March 31, 2014, unless renewed.

26 **JURISDICTION**

- 27 3. This Second Amended Accusation is brought before the Medical Board of California
28 (Board), under the authority of the following laws. All section references are to the Business and

1 Professions Code (Code) unless otherwise indicated.

2 4. Section 2227 of the Code provides that a licensee who is found guilty under the
3 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
4 one year, placed on probation and required to pay the costs of probation monitoring, or such other
5 action taken in relation to discipline as the Division¹ deems proper.

6 5. Section 2234 of the Code states:

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

10 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
11 violation of, or conspiring to violate any provision of [Chapter 5 of the Medical Practice Act].

12 "(b) Gross negligence.

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

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

18 "(2) When the standard of care requires a change in the diagnosis, act, or omission that
19 constitutes the negligent act described in paragraph (1), including without limitation, a
20 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
21 applicable standard of care, each departure constitutes a separate and distinct breach of the
22 standard of care.

23 "(d) Incompetence.

24 "(e) The commission of any act involving dishonesty or corruption which is substantially
25

26 ¹ Pursuant to Business and Professions Code section 2002, "Division of Medical Quality" or
27 "Division" shall be deemed to refer to the Medical Board of California.

28 In addition, all patients are referred to herein by their initials to protect their privacy. The full
names of all patients will be disclosed to Respondent upon a timely request for discovery.

1 related to the qualifications, functions, or duties of a physician and surgeon.

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

3 “(g) The practice of medicine from this state into another state or country without meeting
4 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
5 apply to this subdivision. This subdivision shall become operative upon the implementation of the
6 proposed registration program described in Section 2052.5.

7 “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
8 participate in an interview scheduled by the mutual agreement of the certificate holder and the
9 board. This subdivision shall only apply to a certificate holder who is the subject of an
10 investigation by the board.”

11 6. Section 2261 of the Code states: “Knowingly making or signing any certificate or
12 other document directly or indirectly related to the practice of medicine or podiatry which falsely
13 represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.”

14 7. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
15 adequate and accurate records relating to the provision of services to their patients constitutes
16 unprofessional conduct.”

17 8. Section 725 of the Code states:

18 “(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering
19 of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated
20 acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of
21 the community of licensees is unprofessional conduct for a physician and surgeon, dentist,
22 podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language
23 pathologist, or audiologist.

24 “(b) Any person who engages in repeated acts of clearly excessive prescribing or
25 administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of
26 not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by
27 imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and
28 imprisonment.

1 “(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or
2 administering dangerous drugs or prescription controlled substances shall not be subject to
3 disciplinary action or prosecution under this section.

4 “(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section
5 for treating intractable pain in compliance with Section 2241.5. “

6 9. Section 2241 of the Code states:

7 “(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs,
8 including prescription controlled substances, to an addict under his or her treatment for a purpose
9 other than maintenance on, or detoxification from, prescription drugs or controlled substances.

10 “(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or
11 prescription controlled substances to an addict for purposes of maintenance on, or detoxification
12 from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections
13 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this
14 subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer
15 dangerous drugs or controlled substances to a person he or she knows or reasonably believes is
16 using or will use the drugs or substances for a nonmedical purpose.

17 “(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also
18 be administered or applied by a physician and surgeon, or by a registered nurse acting under his
19 or her instruction and supervision, under the following circumstances:

20 “(1) Emergency treatment of a patient whose addiction is complicated by the presence of
21 incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

22 “(2) Treatment of addicts in state-licensed institutions where the patient is kept under
23 restraint and control, or in city or county jails or state prisons.

24 “(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety
25 Code.

26 “(d) (1) For purposes of this section and Section 2241.5, “addict” means a person whose
27 actions are characterized by craving in combination with one or more of the following:

28 “(A) Impaired control over drug use.

1 “(B) Compulsive use.

2 “(C) Continued use despite harm.

3 “(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due
4 to the inadequate control of pain is not an addict within the meaning of this section or Section
5 2241.5.

6 10. Section 2241.5 of the Code states:

7 “(a) A physician and surgeon may prescribe for, or dispense or administer to, a person
8 under his or her treatment for a medical condition dangerous drugs or prescription controlled
9 substances for the treatment of pain or a condition causing pain, including, but not limited to,
10 intractable pain.

11 “(b) No physician and surgeon shall be subject to disciplinary action for prescribing,
12 dispensing, or administering dangerous drugs or prescription controlled substances in accordance
13 with this section.

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

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

18 “(2) Violates Section 2241 regarding treatment of an addict.

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

21 “(4) Violates Section 2242.1 regarding prescribing on the Internet.

22 “(5) Fails to keep complete and accurate records of purchases and disposals of substances
23 listed in the California Uniform Controlled Substances Act (Division 10 (commencing with
24 Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal
25 Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or
26 pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A
27 physician and surgeon shall keep records of his or her purchases and disposals of these controlled
28 substances or dangerous drugs, including the date of purchase, the date and records of the sale or

1 disposal of the drugs by the physician and surgeon, the name and address of the person receiving
2 the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall
3 otherwise comply with all state recordkeeping requirements for controlled substances.

4 “(6) Writes false or fictitious prescriptions for controlled substances listed in the California
5 Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse
6 Prevention and Control Act of 1970.

7 “(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of
8 Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of
9 Division 10 of the Health and Safety Code.

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

14 “(e) Nothing in this section shall prohibit the governing body of a hospital from taking
15 disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and
16 809.5.”

17 11. Section 2242 of the Code states:

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

21 “(b) No licensee shall be found to have committed unprofessional conduct within the
22 meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of
23 the following applies:

24 “(1) The licensee was a designated physician and surgeon or podiatrist serving in the
25 absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs
26 were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return
27 of his or her practitioner, but in any case no longer than 72 hours.

28 “(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed

1 vocational nurse in an inpatient facility, and if both of the following conditions exist:

2 “(A) The practitioner had consulted with the registered nurse or licensed vocational nurse
3 who had reviewed the patient's records.

4 “(B) The practitioner was designated as the practitioner to serve in the absence of the
5 patient's physician and surgeon or podiatrist, as the case may be.

6 “(3) The licensee was a designated practitioner serving in the absence of the patient's
7 physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized
8 the patient's records and ordered the renewal of a medically indicated prescription for an amount
9 not exceeding the original prescription in strength or amount or for more than one refill.

10 “(4) The licensee was acting in accordance with Section 120582 of the Health and Safety
11 Code.”

12 12. Section 2238 of the Code states:

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

16 13. Section 11190 of the Health and Safety Code states:

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

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

21 (2) The date.

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

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

26 (c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled
27 substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and
28 Professions Code, the prescriber shall record and maintain the following information:

1 (A) Full name, address, and the telephone number of the ultimate user or research subject,
2 or contact information as determined by the Secretary of the United States Department of Health
3 and Human Services, and the gender, and date of birth of the patient.

4 (B) The prescriber's category of licensure and license number; federal controlled substance
5 registration number; and the state medical license number of any prescriber using the federal
6 controlled substance registration number of a government-exempt facility.

7 (C) NDC (National Drug Code) number of the controlled substance dispensed.

8 (D) Quantity of the controlled substance dispensed.

9 (E) ICD-9 (diagnosis code), if available.

10 (F) Number of refills ordered.

11 (G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

12 (H) Date of origin of the prescription.

13 (2) (A) Each prescriber that dispenses controlled substances shall provide the Department
14 of Justice the information required by this subdivision on a weekly basis in a format set by the
15 Department of Justice pursuant to regulation.

16 (B) The reporting requirement in this section shall not apply to the direct administration of
17 a controlled substance to the body of an ultimate user.

18 (d) This section shall become operative on January 1, 2005.

19 (e) The reporting requirement in this section for Schedule IV controlled substances shall not
20 apply to any of the following:

21 (1) The dispensing of a controlled substance in a quantity limited to an amount adequate to
22 treat the ultimate user involved for 48 hours or less.

23 (2) The administration or dispensing of a controlled substance in accordance with any other
24 exclusion identified by the United States Health and Human Service Secretary for the National
25 All Schedules Prescription Electronic Reporting Act of 2005.

26 (f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the
27 information required by this section for a Schedule II or Schedule III controlled substance, in a
28 format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all

1 of the following:

2 (1) The dispensing of a controlled substance in a quantity limited to an amount adequate to
3 treat the ultimate user involved for 48 hours or less.

4 (2) The administration or dispensing of a controlled substance in accordance with any other
5 exclusion identified by the United States Health and Human Service Secretary for the National
6 All Schedules Prescription Electronic Reporting Act of 2005.”

7 FIRST CAUSE FOR DISCIPLINE

8 (Gross Negligence)

9 14. Respondent is subject to disciplinary action under section 2234, subdivision (b), of
10 the Code in that Respondent was grossly negligent in the care and treatment of patients. The
11 circumstances are as follows:

12 Patient L.Z.

13 15. On or about February 23, 2009 Respondent saw patient L.Z., a 22-year-old male, who
14 was allegedly experiencing pain in his neck and back subsequent to an automobile accident on
15 February 3, 2009. Respondent noted the L.Z. had taken OxyContin² “recently to treat his pain
16 condition with good results,” but it is unclear from the documentation from whom the patient had
17 been obtaining the drug. He described the past medical history as “noncontributory,” but earlier
18 in the record indicated the patient had previously been diagnosed with attention deficit disorder
19 with hyperactivity. He listed the medications as OxyContin and Adderall.³ In the review of
20 systems, Respondent indicated the patient denied problem with psychiatric illness or addictions.

21 ² Oxycodone is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic
22 narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as
23 an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result
24 in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic
25 pain. It is sold in its various forms under several brand name including OxyContin (a time-release
26 formula). Oxycodone is also available in combination with acetaminophen (Endocet, Percocet, Roxicet,
27 Tylox, others); aspirin (Endodan, Percodan, Roxiprin, others); and ibuprofen (Combunox). It is a
28 Schedule II controlled substance pursuant to Health and Safety Code section 11055 (b)(1)(M) and a
dangerous drug as defined in Business and Professions code section 4022.

³ Adderall is an amphetamine, and is defined in Health and Safety Code section 11055,
subdivision (d) (1) as a Schedule II controlled substance. It is generally used to treat attention deficit
hyperactivity disorder, but also has a high potential for abuse. It is a dangerous drug as defined in
Business and Professions Code section 4022.

1 There were also negative responses to questions regarding smoking cigarettes, drinking alcoholic
2 beverages, and use of illegal drugs on L.Z.'s patient questionnaire. The questionnaire indicated
3 that L.Z. was taking OxyContin 80 mg daily "when needed" and Adderall 25 mg daily.

4 Respondent's assessment included, neck and low back strain, consideration of cervical disc
5 herniation, cervical facet syndrome, lumbar disc disruption, and also included myofascial pain,
6 sleep disorder, and a history of attention deficit disorder with hyperactivity. His treatment plan
7 included ordering cervical and lumbar MRI scans. Dr. Petraglia prescribed the patient
8 OxyContin, tizanidine⁴, and naproxen⁵. The patient signed an informed consent for opioid
9 therapy and an opioid therapy treatment agreement. On or about February 23, 2009, L.Z. also
10 provided urine for a drug screen. The results of the screen, included, without limitation, a
11 positive for benzodiazepines, which was inconsistent with the history provided by the patient.

12 16. Respondent continued to see patient L.Z. about thirteen more times from March 3,
13 2009, through September 9, 2010. One visit, on June 15, 2010, was in connection with cervical
14 injections. In addition to progress notes, Respondent's medical records included certain reports
15 relating to urine screens, x-rays, and CURES.⁶ There are x-ray reports relating to L.Z.'s cervical,
16 thoracic, and lumbar spine studies at Mission Hospital on or about February 4-5, 2009. An MRI
17 report related to L.Z.'s lumbar spine on or about March 17, 2010. The results of these imaging
18 studies are essentially insignificant with respect to L.Z.'s complaints of pain. A urine toxicology
19 screening, on or about February 23, 2009, was positive for Xanax⁷ and hydromorphone,⁸ although

20 ⁴ Tizanidine is a drug used to relieve the spasms and increased muscle tone caused by multiple
21 sclerosis.

22 ⁵ Naproxen is used to treat pain or inflammation caused by arthritis, ankylosing spondylitis,
23 tendinitis and gout.

24 ⁶ The Department of Justice, Bureau of Narcotics Enforcement maintains the California
25 Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and
26 dispensing of Schedule II and III controlled substances dispensed to patients in California pursuant to
27 Health and Safety Code section 11165. The CURES database captures data from all Schedule II and III
28 controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians.
Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and
resultant abuse of Schedule II and III drugs. Prescribers and pharmacists may request a patient's history of
controlled substances dispensed in accordance with guidelines developed by the Department of Justice.
CURES contains over 100 million entries of controlled substance drugs that were dispensed in California.

⁷ Xanax is a brand name for alprazolam, which is a benzodiazepine drug used to treat anxiety
disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in Business

(continued...)

1 it was indicated that these tests were "inconsistent." A second test on or about April 9, 2009 was
2 positive for oxycodone, and a third test, on or about April 27, 2009, was positive for oxycodone
3 and oxymorphone.⁹ Another test, on or about June 10, 2010, was positive for benzodiazepines,
4 cocaine, hydrocodone,¹⁰ hydromorphone, and oxymorphone. The last urine toxicology screen for
5 L.Z., on or about September 10, 2010, was positive for cocaine,¹¹ alprazolam (Xanax),
6 oxycodone, and oxymorphone. Respondent's records also contained two CURES reports. The
7 first was dated June 24, 2010, and covered the period from June 24, 2009, to June 24, 2010. Only
8 a few of the 36 prescriptions in the list were from Respondent; seven physicians wrote the others,
9 which included multiple prescriptions for every month except June of 2010. The drugs prescribed
10 include morphine, hydromorphone, fentanyl¹² patch, OxyContin, Norco,¹³ Roxicet,¹⁴ Subutex,

11 and Professions code section 4022, and a schedule IV controlled substance and narcotic as defined by
12 Health and Safety Code section 11057 (d). Xanax has a central nervous system depressant effect and
13 patients should be cautioned about the simultaneous ingestions of alcohol and other CNS depressant drugs
14 during treatment with Xanax. Addiction prone individuals (such as drug addicts or alcoholics) should be
under careful surveillance when receiving alprazolam because of the predisposition of such patients to
habituation and dependence.

Benzodiazepines are a class of drugs that produce central nervous system (CNS) depression. They
are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to
prevent seizures. They are most commonly used to treat insomnia and anxiety. There is the potential for
dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance
abuse. Alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), clonazepam (e.g., Klonopin), diazepam (e.g.,
Valium), and temazepam (e.g., Restoril) are the five most prescribed, as well as the most frequently
encountered benzodiazepines on the illicit market. In general, benzodiazepines act as hypnotics in high
doses, anxiolytics in moderate doses, and sedatives in low doses.

⁸ Hydromorphone is an opioid pain medication used to treat moderate to severe pain. It has been
marketed, in its varying forms, under a number of brand names, including Dilaudid. Hydromorphone is a
Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J),
and a dangerous drug pursuant to Business and Professions Code section 4022.

⁹ Oxymorphone is an opiate analgesic used to relieve moderate to severe pain. It is a dangerous
drug as defined in Business and Professions code section 4022, a Schedule II controlled substance and
narcotic as defined by Health and Safety Code section 11055 (b)(1)(N).

¹⁰ Hydrocodone is a semisynthetic opioid analgesic similar to but more active than codeine; used
as the bitartrate salt or polistirex complex as an oral analgesic and antitussive. It is marketed, in its
varying forms, under a number of brand names, including Vicodin, Hycodan (or generically Hydromet),
Lorcet, Lortab, Norco, and Hydrokon, among others. Hydrocodone also has a high potential for abuse.
Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055,
subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

¹¹ Cocaine is illegal to possess under California Health and Safety Code section 11350.

¹² Fentanyl is a potent, synthetic narcotic analgesic with a rapid onset and short duration of action.
It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision
(c)(8), and a dangerous drug pursuant to Business and Professions Code section 4022.

¹³ Norco is a brand name for acetaminophen and hydrocodone. Acetaminophen is a widely used

(continued...)

1 ¹⁵Suboxone, ¹⁶Vyvanse, ¹⁷Adderall, Testim (steroids), alprazolam (Xanax), and clonazepam
2 (Klonopin).¹⁸ The second CURES report on dated January 11, 2011, covered the period from
3 January 11, 2010, until January 11, 2011. More than half of the drugs were prescribed after June
4 1, 2010. In addition to Respondent, five other prescribers were on the list. The drugs on the list
5 included hydromorphone, oxycodone, OxyContin, Norco, Opana,¹⁹ Subutex, Xanax, and
6 Klonopin. Respondent continued to see patient L.Z. after the first visit as follows below.

7 17. On or about March 3, 2009 Respondent saw L.Z. Respondent wrote the following
8 note in his record for that visit:

9 "[L.Z.] also states he is [sic] used OxyContin in the past, obtained from the street as well as
10 through prescription medications. Although he denies of [sic] using this medication, he
11 appears overly concerned with his pain and seeking medication of this type to relieve it."

12 Respondent's records failed to include any discussion of alternative treatments. The medication
13 section of the note stated, "OxyContin (80 milligrams when needed) Adderall." Although the
14 associated patient questionnaire, dated March 4, 2009, indicates that L.Z. was also taking

15
16 over-the-counter analgesic (pain reliever) and antipyretic (fever reducer). It is commonly used for the
17 relief of headaches, other minor aches and pains, and is a major ingredient in numerous cold and flu
18 remedies. In combination with opioid analgesics, paracetamol can also be used in the management of
19 more severe pain such as post surgical pain and providing palliative care in advanced cancer patients.
20 Acute overdoses of paracetamol can cause potentially fatal liver damage and, in rare individuals, a normal
21 dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including
22 under the brand name Tylenol. Acetaminophen comes in combination with other medications, including
23 hydrocodone.

24 ¹⁴ Roxicet is brand name for a drug that contains a combination of acetaminophen and oxycodone.

25 ¹⁵ Subutex is a formulation of buprenorphine, which is used to treat opioid dependence.

26 ¹⁶ Suboxone is a drug used to treat opiate addiction that contains buprenorphine and naloxone.
27 Buprenorphine is an opioid medication that is similar to other opioids such as morphine, codeine, and
28 heroin, however, it produces less euphoric effects and therefore may be easier to stop taking. Naloxone
blocks the effects of opioids such as morphine, codeine, and heroin.

29 ¹⁷ Vyvanse is a brand name for Lisdexamfetamine. It is a stimulant used as part of a treatment
30 program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing,
31 controlling actions, and remaining still or quiet than other people who are the same age) in adults and
32 children. It is a psychostimulant prodrug of the phenethylamine and amphetamine chemical classes. It is a
33 dangerous drug as defined in Business and Professions Code section 4022.

34 ¹⁸ Clonazepam is a benzodiazepine-based sedative. It is generally used to control seizures and
35 panic disorder. It is also sold under the brand name Klonopin. It is a Schedule IV controlled substance
36 pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in
37 Business and Professions Code section 4022.

38 ¹⁹ Opana is a brand name for oxymorphone.

1 Wellbutrin,²⁰ there is no reference to this drug in Respondent's note. The physical exam section
2 of the note is essentially identical to that contained within the February 23, 2009 note, except for
3 minor additions (e.g., "The sensory examination is within normal limits with the exception of
4 bilateral hanbd [sic] numbness" [which is added in the cervical spine section]). The plan for this
5 visit includes a recommendation for "modified OxyContin prescription," and notes that "patient
6 states he was previously taking 80 mg but no specific prescribing physician can be identified."
7 On or about March 4, 2009, Respondent prescribed OxyContin 60 mg, quantity 90, with
8 instructions to take one three times daily.²¹ He also prescribed Soma²² to the patient. However,
9 the consultation report indicated that Respondent intended to prescribed Zanaflex²³ rather than
10 Soma for treatment of muscle spasm. Respondent's documentation for this visit also does not
11 provided sufficient explanation for his increasing the dosage of OxyContin from 80 mg daily to
12 180 mg daily, notwithstanding that L.Z.'s pain intensity had not changed. His pain intensity was
13 6 out of 10 on or about February 23, 2009, and March 3, 2009.

14 18. On or about March 16, 2009 Respondent saw L.Z. again. The record for this visit is
15 only a brief handwritten note. His plan included injections and recommendations MRI scans.
16 Respondent prescribed OxyContin 80 mg (90 pills), with instruction to take one three times daily.
17 He also prescribed Soma 350 mg (120 pills) and Cymbalta²⁴ 60 mg, to be taken twice daily.
18 Respondent's documentation for this visit also does not provide sufficient explanation for his

19 ²⁰ Wellbutrin is a trade name for bupropion. It is used to depression and to assist with smoking
20 cessation. It is a dangerous drug as defined in Business and Professions Code section 4022. Bupropion is
also marketed as, Zyban, Voxra, Budeprion, or Aplenzin.

21 ²¹ However, the previous prescription on February 23, 2009 was for OxyContin 40 mg (60 pills)
two times a day. Furthermore, while the prescription, medication log and patient questionnaire were all
22 dated March 4, 2009, Respondent's consultation report was dated March 3, 2009.

23 ²² Soma is a trade name for carisoprodol. It is a muscle-relaxant and sedative. It is dangerous
drug as defined in Business and Professions code section 4022.

24 ²³ Zanaflex is the trade name for tizanidine, which is a short-acting muscle relaxer used to treat
spasticity by temporarily relaxing muscle tone. It is used to relieve the spasms and increased muscle tone
caused by multiple sclerosis, stroke, or brain or spinal injury.

25 ²⁴ Cymbalta is a brand name for duloxetine, which is an antidepressant in a group of drugs called
26 selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Cymbalta is used to treat major
depressive disorder and general anxiety disorder. Cymbalta is also used to treat a chronic pain disorder
27 called fibromyalgia, treat pain caused by nerve damage in people with diabetes (diabetic neuropathy) and
to treat chronic musculoskeletal pain, including discomfort from osteoarthritis and chronic lower back
28 pain.

1 increasing the dosage of OxyContin dosage from 180 mg to 240 mg daily or why he changed the
2 strength of the Soma formulation (i.e., it was increased from 250 mg to 350 mg). Respondent
3 also failed to discuss the inconsistent urine drug screen result collected on or about February 23,
4 2009, and available on or about March 16, 2009, in which L.Z. tested positive for benzodiazepine
5 yet had not reported taking a benzodiazepine. There is also a consultation report, dated March 17,
6 2009, relating to the brother of L.Z., misfiled in L.Z.'s medical records.

7 19. On or about April 9, 2009, Respondent saw L.Z. again. This record is a handwritten
8 note. Respondent failed to address the urine drug screen results at this visit. Respondent refilled
9 the prescriptions for OxyContin and Soma at this time and also added a new prescription for
10 Vicodin 5/500 (120 pills), which he explained in his interview with the Medical Board was for
11 treatment of breakthrough pain. There is no explanation in the note regarding why the patient
12 needed the additional prescription for Vicodin. On or about April 9, 2009, L.Z. also provided
13 urine for a drug screen.

14 20. There is a patient questionnaire, Patient Information Update, dated April 16, 2009,
15 but there is no accompanying physician note in the record to verify that a visit occurred on this
16 date.

17 21. On or about April 27, 2009, Respondent saw L.Z. Respondent noted that L.Z.'s
18 physical therapy and massage had been helpful, and that he had been using OxyContin on a
19 regular basis and doing well with this regimen. Respondent also reviewed the results of the urine
20 test from the initial visit in February 2009, and noted the inconsistent results. He said, "Although
21 his urine initially was in noncompliance, there is no reason to suspect that he is not taking the
22 OxyContin prescribed to him at this time" Respondent indicated that while the lumbar MRI was
23 completed, the cervical MRI had not been done "due to patient non-compliance in scheduling."
24 Respondent reiterated the same physical examination findings as in his earlier typed reports. In
25 his assessment section, he added the diagnosis of "opioid dependence syndrome." Respondent
26 recommended that the patient see "a support counselor or psychologist" for his attention deficit
27 disorder, and undergo regular urine testing. Although Respondent also recommended a CURES
28 report; there is no evidence that he obtained a CURES report at this point. The April 27, 2009,

1 chart note also indicated that Respondent would refill L.Z.'s prescription for OxyContin and
2 naproxen, but there is no evidence in Respondent's medical records (i.e., a copy of the
3 prescription or a notation in the medication log) that this was done at that time. However, the
4 CVS Pharmacy records indicate three prescriptions that Respondent issued on that date to L.Z.,
5 including OxyContin 80 mg (30 pills), Norco 10/325 mg (160 pills), and Soma 350 mg (90 pills).
6 However, there was no prescription for naproxen, which is another inconsistency in the
7 documentation.

8 22. On or about April 27, 2009, L.Z. also provided urine for a drug screen, the results for
9 which were available on May 18, 2009.

10 23. Respondent next saw L.Z. on or about May 20, 2009. Respondent's records for that
11 day provided, "OxyContin has been increased from initial visit when he was prescribed 40 mg.
12 He has called on a regular basis repeatedly asked for increasing medication from 60 mg 80 mg
13 dosing over the last three months." Although he noted that the first urine test results obtained in
14 February 2009, found no OxyContin in his urine, Respondent stated that his concerns "about
15 diversion of medication was somewhat diminished by this confirmation study" because L.Z.'s
16 more recent urine drug testing in March 2009, was positive for oxycodone. Respondent also
17 noted that L.Z.'s neck pain intensity was 8 out of 10 and his back pain was 7-8 out of 10. He
18 also indicated that L.Z. was still noncompliant in scheduling the cervical spine MRI (which he
19 had previously recommended). He reiterated the same physical examination findings as in his
20 previous notes. He changed his diagnosis from opioid dependence syndrome to opioid tolerance.
21 Respondent also reiterated his treatment recommendations and again recommended a CURES
22 report but did not obtain one. Respondent issued refills for OxyContin, Soma, and Norco, with
23 the only change being reduction in the quantity of Soma from 120 to 90 tablets.

24 24. Respondent next saw L.Z. on or about April 1, 2010, nearly one year from the prior
25 visit. His record for this visit indicated that L.Z. reported that he had "been receiving OxyContin,
26 Soma, Xanax for continued management of his condition." Respondent also indicated that he
27 reviewed the CURES report indicating the patient had been "prescribed multiple combinations of
28 analgesics, muscle relaxants, anxiolytic medications, detoxification medications such as

1 agonist/antagonist combinations over the past year.” And, Respondent wrote, “Unfortunately, the
2 medications described have been written by multiple providers.” He then wrote that he reviewed
3 the opioid contract with the patient and counseled him. However, the CURES report is not in the
4 patient’s medical record. Respondent noted that he inquired about the other doctors that L.Z. was
5 seeing and asked why the patient no longer saw any of those physicians. Respondent also
6 reported that the patient shrugged his shoulder and gave no specific answer to that question.
7 Respondent also noted that L.Z. had been involved in a second motor vehicle accident on July 27,
8 2009, “where he lost control of his motorcycle while under the influence of alcohol.” Although
9 Respondent noted L.Z. had been hospitalized for treatment of injuries to his shoulders, right wrist,
10 neck and back, he had no hospital records available for review related to that second injury.
11 Respondent recommended reducing the dose of OxyContin to 40 mg twice daily, because the
12 patient “had a drug hiatus.” Respondent felt this represented “a reasonable taper of medications
13 in an effort to review federal Department of Justice cures report.” Respondent prescribed
14 OxyContin 40 mg (60 pills), Soma 350 mg (90 pills), and Xanax 2 mg (90 pills). Respondent
15 indicated that the prescription for Xanax was for “anxiety,” but did not provide appropriate
16 history or examination findings to support the prescription of this drug, which he had not
17 previously prescribed the patient, despite the fact that L.Z. had previously tested positive on a
18 urine drug screen for benzodiazepines and that the patient had recently been in an accident due to
19 driving under the influence of alcohol. Respondent also wrote that:

20 “[L.Z.] states that his pain is improved with medication that has been provided by other
21 practitioners over the past eight months. He has not been compliant with our mandatory
22 opioid agreement to see only one physician for his medication needs. The need for such
23 opiate contract was again discussed with [L.Z.] and he understands and agrees to comply.”

24 25. Respondent next saw L.Z. on April 29, 2010. In his note for that day, Respondent
25 reiterated the history and examination findings of the note from April 1, but included new
26 information from L.Z. stating that lithium and Seroquel²⁵ had been added to his medical regimen.

27 _____
28 ²⁵ Seroquel (quetiapine) is used to treat the symptoms of schizophrenia and bipolar disorder.

1 There is no discussion as to why the patient was taking these medicines. Respondent changed his
2 diagnosis of opioid dependence to "substance abuse disorder." The medication log does not
3 indicate a refill of medications that day, but there is a copy of a prescription that appears to be
4 dated April 29, 2010 for OxyContin 40 mg (90 pills), Soma 350 mg (90 pills), and Xanax 2 mg
5 (90 pills). There is no documentation explaining why Respondent increased L.Z.'s prescription
6 for OxyContin from a quantity of 60 to 90 tablets, despite making a diagnosis of substance abuse
7 disorder, and recommending a reduction of the OxyContin prescription. Similar to the previous
8 visit, Respondent's notes fail to provide a justification for the prescription for Xanax. Indeed, in
9 his "current history update," Respondent noted that L.Z. used Dilaudid and Xanax, but stated that
10 Respondent had "not prescribed these medications to date to this individual," even though
11 Respondent had prescribed Xanax to L.Z. at the April 1, 2010 visit.

12 26. Respondent saw L.Z. again on June 10, 2010. Much of the progress note for this visit
13 is substantially the same as the note for the previous visit. Respondent wrote that the patient's
14 lithium had been discontinued, but did not include further explanation. Respondent again noted
15 the patient was using Xanax but wrote, "I had not prescribed these medications to date to this
16 individual." Respondent changed his diagnosis of substance abuse disorder back to the diagnosis
17 of opioid dependence syndrome without explanation. In the discussion section, Respondent
18 wrote:

19 "[L.Z.] states that his pain has improved with medication that has been provided by other
20 practitioners over the past eight months. He states that when the medications are not taken,
21 his pain returns unabated. He has not been compliant with our opioid agreement which
22 mandates the patient to see only one physician for his medication needs. The need for such
23 opiate contract was again discussed with [L.Z.] and he understands and agrees to comply.
24 He states the reason he has seen other physicians for medication is that they prescribe other
25 types of medications for him."

26 Respondent also recommended that L.Z. receive treatment with a support/crisis counselor,
27 psychiatrist or psychologist for attention deficit disorder and likely substance abuse disorder, but
28 noted that L.Z. denied his request. Respondent also collected a urine specimen for random urine

1 drug screen at this visit. He prescribed OxyContin 40 mg (60 pills), Soma 350 mg (90 pills), and
2 Xanax 2 mg (90 pills).

3 27. Respondent's records also include a document entitled, "Rapid Assessment Drug and
4 Detox," dated June 14, 2010. The handwritten notes by Respondent's alcohol and drug treatment
5 counselor (Drug Counselor) state as follows:

6 "Client claims he struggles with his meds. Questions asked revealed that he is using his
7 meds inappropriately. Mother claims she supports her son in his willingness to stop using
8 meds. . . . Pt continues to use his meds inappropriately. He looks like he is high and under
9 influence. Conversation leads to talking about detox or coming off meds completely. . . .
10 [mental status findings include] word salad, erratic thoughts, intoxication, constriction,
11 erratic unusual behavior. . . . Assessment: addictive personality, drug-seeking behavior,
12 personality disorder. . . . Client exhibits that he is using meds inappropriately, that he
13 should consider detox or cutting down so he can manage his medication responsibly. . . .
14 Plan: detox, treatment with addictionologist, continued screening and monitoring. . . .
15 Continue to follow-up, monitor his behavior. Suggested he consider detox. Rehab."

16 28. On or about June 15, 2010, L.Z. received cervical injections at Respondent's office.

17 29. Respondent next saw L.Z. on or about June 22, 2010. Much of the progress note for
18 his visit is substantially the same as the note for the previous visit. For example, the physical
19 examination was repeated from the June 10, 2010 note. The results of the urine drug screen from
20 June 10, 2010 were not mentioned in this progress note. The medication log and the copy of the
21 prescription indicate that Respondent prescribed OxyContin 40 mg (60 pills), Soma 350 mg (90
22 pills), and Xanax 2 mg (90 pills) on this date. Respondent's records indicate that it was reported
23 that the June 22, 2010 prescription was "thrown in trash." Accordingly another prescription was
24 issued for the same drugs on or about June 24, 2010. However, the OxyContin prescription had
25 been increased, without explanation, from the prior prescription from 40 mg to 60 mg.

26 30. Respondent's Drug Counselor saw L.Z. again on or about June 22, 2010. He
27 indicated L.Z. wanted a higher dose of medicine and to report that he had been "taking 80 mg of
28 meds when he is given 40 mg dose." L.Z. was described as "overmedicated" and "drug seeking"

1 and said his mother seemed "overwhelmed with situation." He noted the patient tested positive
2 for cocaine in his urine and continued "to act like a full-blown addict." He recommended the
3 patient be more responsible with his medicine and considered possible termination from the
4 clinic.

5 31. Respondent saw L.Z. on or about June 24, 2010. At this visit, Respondent wrote
6 that:

7 "[It was] highly unlikely that this individual lost the prescription of 6-22-10. However, to
8 suggest that the patient's mother was complicit with his abuse of the medication would be a
9 stretch. The medication was rewritten accordingly. OxyContin had been increased from
10 initial visit when he was prescribed 40 mg. he [sic] continues to ask for higher strengths of
11 OxyContin stating that he is not getting the relief from the previous prescribed dosage of
12 OxyContin. Such requests for more medication have been repeatedly denied."

13 The note on June 24, 2010, reiterated statements that were in many previous notes relative to
14 urine drug screens from 2009 and refers to L.Z. having tested positive for cocaine "on today's
15 urine exam." However, there was no record of any specimen for a urine drug screen on June 24,
16 2010. Furthermore, Respondent failed to adequately address the results of the urine drug screen
17 from June 10, 2010, where L.Z. tested positive for cocaine and marijuana.²⁶ Indeed, Respondent
18 failed to adequately address this violation of the Contract for Use of Opioid [sic] Medications that
19 L.Z. signed at his initial visit. Respondent also changed his diagnosis to opioid dependence
20 syndrome and chronic pain with substance abuse disorder and physiologic dependence. In the
21 recommendations section, the physician recommended reducing the OxyContin. However,
22 Respondent issued a replacement prescription on this date for the lost prescription from June 22,
23 2010 that increased the dosage of OxyContin, from 40 mg to 60 mg, which contradicted his
24 recommendation.

25
26 ²⁶ At his interview with the Board investigator, Respondent stated that a patient might go to a
27 wedding and do cocaine, but he does not dismiss patients for one illicit in a urine screen, because it would
28 put a patient "out in the street" because he would rather have him in a controlled setting so he can "watch
him." He stated that there would be grounds for dismissal if there was a second illicit result.

1 32. Respondent's Drug Counselor saw L.Z. again on or about June 24, 2010. He
2 described the patient as intoxicated with "erratic unusual behavior." He stated that the "Client
3 was counseled that this is a non-compliant behavior this time we would honor there [sic] request
4 but in future they need to handle meds appropriately." He recommended psychiatric counseling,
5 detox, termination from the pain clinic, and continued meetings with the patient and his family.

6 33. Respondent's Drug Counselor saw L.Z. again on or about July 6, 2010. He stated
7 that L.Z. was "looking for additional medication" and "complaining of pain." He also stated that
8 L.Z. "will do and say whatever it takes to get medication at this time." He again described him as
9 appearing intoxicated and said "client needs to detox-down or lower doses appropriately. Client
10 may be seeing other pain management Dr." The Drug Counselor recommended detox for L.Z.

11 34. Respondent saw L.Z. on or about August 4, 2010. In connection with this visit,
12 Respondent wrote:

13 "He often is stating that the medication does not completely relieve his pain. He continues
14 to ask for higher dosing of OxyContin. He is denying the need/request for detoxification at
15 this time. Parental supervision and cooperation was obtained from patient's mother in this
16 regard. Urine has revealed THC, cocaine, oxycodone, benzodiazepine, suboxone in the
17 urine." . . . He states that he has been using OxyContin 80 mg on a regular basis for his
18 pain. Due to likely heightened pain perception of the opioid dependence syndrome and the
19 fact that parental consent was given from the patient's mother while in clinic, the strength of
20 OxyContin was increased to 80 mg and was prescribed today. The patient's mother states
21 that the prescription dated 6-22-10 was lost and it was thrown in the trash. This was
22 corroborated and she appeared to be taking on a more caretaker role in the administration
23 medication to her son. This was addressed with addiction counselor [M.L.] an agreement
24 was made for therapeutic trial of higher dosing of medication to support elimination of non-
25 prescribed illicit substances."

26 Respondent also wrote, "However on today's urine exam, benzodiazepine, morphine, oxycodone
27 and THC were undetected. The patient was, however, positive for cocaine." There is no record
28 that L.Z. provided a specimen for urine drug testing on August 4, 2010. Respondent also

1 recommended a "temporary increase of OxyContin to 80 mg in support of opiate dependence
2 syndrome." Respondent prescribed OxyContin 80 mg (60 pills), Soma 350 mg (90 pills), and
3 Xanax 2 mg (90 pills).

4 35. Respondent's records also included copies of prescriptions, dated August 16, 2010,
5 for OxyContin, Soma, Xanax, and Opana. Respondent prescribed OxyContin 80 mg (150 pills),
6 Soma 350 mg (120 pills), Xanax 2 mg (120 pills), and Opana ER 40 mg (60 pills). However,
7 Respondent's records are devoid of any corresponding office visit notes or any explanation
8 regarding why these prescriptions were issued. There was no explanation regarding why
9 Respondent increased the quantities of tablets on the prescriptions for OxyContin, Soma, and
10 Xanax. There is also no explanation as to why L.Z. needed refill of these three medicines only 12
11 days after he had received prescriptions for a month supply of the drugs. Similarly, there is no
12 explanation why L.Z. received a prescription for Opana ER (extended release), which is another
13 long-acting opioid similar to OxyContin. They are also not noted in the medication log.

14 36. Respondent last saw L.Z. on or about September 9, 2010. At this visit, Respondent
15 noted that L.Z. returned "after a one-month trial of increased medications in an effort to reduce
16 his use of illicit nonprescribed substances." Respondent also wrote that, "Urine testing again
17 reveals presence of cocaine along with the presence of prescribed benzodiazepine and
18 oxycodone." According to Respondent, L.Z. was "denying/refusing the need for detoxification at
19 this time." Respondent also wrote:

20 "Addiction specialist, [Drug Counselor] has been in conference with the patient and his
21 family since May suggesting the need reducing medications and an alternative rehabilitation
22 program. I have agreed that these assessments have recommended the same [sic]. The
23 OxyContin will be reduced in an effort to obtain stability with physiologic dependence."

24 However, later in the same paragraph, Respondent contradicts the earlier reporting by
25 reiterating statements he made in a prior report about increasing the dose of OxyContin to address
26 the "strong possibility of physiologic tolerance." In addition, in the recommendations section,
27 Respondent wrote that he recommended a "temporary increase of OxyContin to 80 mg in support
28 of opiate tolerance." However, the medication log indicated that L.Z. was prescribed OxyContin

1 40 mg (60 pills), Soma 350 mg (90 pills), Xanax 2 mg (90 pills), and Opana ER 40 mg (60 pills).
2 In addition, Respondent's documentation failed to explain why he prescribed L.Z. another long-
3 acting opioid, Opana ER, on this date or on the prior date of August 16, 2010.

4 37. On and about February 23, 2009, and thereafter, Respondent's prescribing of
5 medications to L.Z., as he presented, represents gross negligence.

6 38. On and about February 23, 2009, and thereafter, Respondent was grossly negligent
7 when he failed to adequately manage L.Z.

8 Patient S.D.

9 39. On or about May 20, 2009, Respondent saw patient S.D., a 21-year-old woman who
10 claimed to have injured her lower back several years prior playing volleyball and had complaints
11 of bilateral shoulder pain. According to S.D., she suffered from ten years of low back pain
12 stemming from years of playing competitive volleyball in high school and college. Her previous
13 treatment consisted of medications, physical therapy, and lumbar facet injections with
14 radiofrequency ablation (nerve destruction). She reported an increase in pain because of recent
15 excessive driving. She also complained of a multitude of symptoms: spasm in her neck with
16 prolonged standing, occasional numbness in hips and buttocks, weakness and tingling through the
17 lower extremity secondary to muscle weakness, and pain with standing, walking, and sitting. Her
18 current medications then included OxyContin (which was prescribed to her friend, but not listed
19 in her pain management questionnaire) and Lexapro²⁷. She reported pain as 8 out of 10.

20 Respondent's record failed to include an adequate family history, social history, addiction history,
21 or psychiatric history. However, in addition to a computer printed record, Respondent also had a
22 difficult to decipher preprinted medical record sheet for S.D. on this date and the past medical
23 history included a check mark beside "opioid dependence," without further information. Her
24 muscle strength was 4/5 in all muscle groups in both upper extremities, and she was weak
25 throughout both lower extremities. Respondent diagnosed S.D. as follows: 1) bilateral shoulder

26
27 ²⁷ Lexapro is a brand name for escitalopram. It is included in the class of drugs called selective
28 serotonin reuptake inhibitors (SSRIs). This class of drugs is used to treat depression, anxiety, and other
mood disorders. It is a dangerous drug as defined in Business and Professions Code section 4022.

1 arthropathy (consider labral tear); 2) sleep disorder; 3) persistent and recurrent back pain with
2 lumbar disc herniation, 4) lumbar neuralgia; and 5) low back pain syndrome status post
3 radiofrequency ablation lumbar facets. Respondent's recommended treatments included MRI
4 scans of the shoulders and lumbar spine, OxyContin, Soma, ibuprofen, lumbar epidural steroid
5 injections, and physical therapy. Respondent wrote a prescription for OxyContin 80 mg (60
6 pills), Soma 250 mg (120 pills), and Restoril 30 mg (30 pills).

7 40. Respondent next saw the patient on or about June 1, 2009. In her patient information
8 update form, dated June 1, 2009, S.D. stated that her back pain was better but her shoulder pain
9 was worse. She also indicated that she was taking OxyContin, Soma, and a sleeping pill.

10 Respondent's record for this visit was prepared on a preprinted form that included handwritten
11 notes. The patient complained of pain in the right shoulder that felt like a pinched nerve. The
12 preprinted form was difficult to decipher due to illegible handwriting and a series of checkboxes
13 and items that can be circled that did not include more detailed explanations. Respondent
14 prescribed the following to S.D. on or about June 1, 2009 and June 2, 2009, Norco 10/325 mg
15 (120 pills), Soma 250 mg (120 pills), OxyContin 80 mg (90), and Opana 40 mg. (60 pills).

16 41. A drug test on a biological sample from S.D. collected on or about June 1, 2009, was
17 negative for any of the tested drugs.

18 42. On or about June 2, 2009, Respondent performed a procedure on S.D. that included
19 epidural injections.

20 43. Respondent next saw the patient on or about June 10, 2009. His record for this date
21 was made on a similarly difficult to decipher preprinted sheet. A patient questionnaire that is
22 undated also appears near this preprinted form in Respondent's chart, and in it, S.D. reports that
23 her pain has decreased and her symptoms improved.

24 44. On or about July 14, 2009, Respondent performed another procedure on S.D. that
25 included epidural injections. On or about July 14, 2009, Respondent also prescribed the
26 following to S.D.: OxyContin 80 mg (90 pills), Norco 10/325 mg (120 pills), Soma 250 mg (120
27 pills), and Opana ER 40 mg (60 pills). However there is an inconsistency in the prescription log.

28 45. Respondent next saw the patient on or about August 4, 2009. His record for this date

1 was made on a similarly difficult to decipher preprinted sheet. Prescription copies and the
2 medication log show Respondent prescribed Opana 40 mg (60 pills), OxyContin 80 mg (30 pills),
3 Soma 350 mg (100 pills), and Norco 10/325 mg (90 pills).

4 46. On or about September 10, 2009, another doctor performed a surgery on S.D.'s right
5 shoulder.

6 47. Respondent next saw the patient on or about January 12, 2010. His record for this
7 date was made on a similarly difficult to decipher preprinted sheet. In her patient information
8 update form dated that same day, S.D. stated that her right shoulder surgery helped, but her other
9 shoulder and back were bad. Respondent also listed the following diagnoses in this notes: lumbar
10 disc protrusion, sciatica, radiculitis, facet syndrome, discogenic pain, and two others that are
11 illegible. Respondent also prescribed the following drugs to S.D. at that time: Opana ER 40 mg
12 (60 pills), Soma 350 mg (90 pills), and Norco 10/325 mg (90 pills).

13 48. Respondent next saw the patient on or about January 19, 2010. His record for this
14 date was made on a similarly difficult to decipher preprinted sheet. In her patient information
15 update form dated that same day, S.D. complained that her lower back and right shoulder and left
16 shoulder hurt. She also stated that "oxy, opanas, norcos, somas help a lot." Respondent also
17 prescribed the following drugs to S.D. at that time: OxyContin 80 mg (90 pills), Soma 350 mg
18 (90 pills), and Norco 10/325 mg (90 pills). Respondent also wrote a note advising that S.D. to not
19 engage in "forward flexion" exercises (bending at the waist).

20 49. Respondent's next record for this patient was dated March 31, 2011, and was made
21 on a similarly difficult to decipher preprinted sheet. In her Initial Pain Management
22 Questionnaire, dated March 31, 2011, S.D. listed the following medications that were prescribed
23 to her by her primary care physician Dr. O.: Lexapro, Soma, Opana, Norco, and "Roxy." She
24 also signed the form and dated it March 30, 2011. Respondent prescribed to S.D. the following
25 medications on March 31, 2011: Norco 10/325 mg (60 pills), ibuprofen 800 mg (60 pills), and
26 Soma 350 mg (60 pills).

27 50. During his interview with the Board investigator, Respondent expressed his concern
28 that if he withheld opiate medications from S.D., she might have withdrawal syndrome and

1 attempt to obtain medications on the street.

2 51. On and about May 20, 2009, and thereafter, Respondent's record keeping with
3 respect to patient S.D. represents gross negligence.

4 52. On and about May 20, 2009, and thereafter, Respondent was grossly negligent when
5 he failed to adequately assess and treat S.D.

6 53. On and about May 20, 2009, and thereafter, Respondent's prescribing of medications
7 to S.D., as she presented, represents gross negligence.

8 54. On and about May 20, 2009, and thereafter, Respondent's prescribing of high-dose
9 opiates and sedatives to S.D., as she presented, represents gross negligence and excessive
10 prescribing.

11 Patient J.J.

12 55. On or about October 18, 2007, Respondent initially saw patient J.J., a 22-year-old
13 man for the first time. His record for this date was made on a difficult to decipher preprinted
14 sheet similar to the one used for patient S.D. On that date, Respondent prescribed the following
15 drugs to J.J.: OxyContin 40 mg (60 pills) and ten 25-mcg/hour Duragesic²⁸ patches.

16 56. Respondent's records for J.J. also contain the records for other healthcare providers,
17 which are described briefly as follows:

18 A. An orthopedic consult record by Dr. A.F., dated July 25, 2007, provided that
19 J.J. was 22 years old, and was seen for severe burning pain in the inner left groin for just over a
20 year, associated with numbness of the skin in that area. However, the record indicated that the
21 "patient reports no specific traumatic event causing this severe pain." The patient also reported
22 that he had taken ibuprofen, Norco and other medications, but settled on Norco. Physical therapy
23 did not help. His Past Medical History is otherwise significant for a nervous breakdown and bad
24 headaches. Physical examination is normal except for modest reduction of lumbar range of
25 motion and mild "breakaway" weakness all over. Dr. A.F.'s plan included ruling out central
26

27 ²⁸ Duragesic and Durogesic are trade names of fentanyl transdermal patches, used for relief of
28 moderate to severe pain. The patches release fentanyl, a potent opioid, slowly through the skin.

1 pathology by obtaining an MRI of the lumbar spine; providing a steroid taper; and Norco for a
2 month and Neurontin 600 mg at night.

3 B. A note by Dr. A.F. for a follow up visit, dated July 30, 2007, reported that the
4 patient was having a lot more pain in the medial thighs. The pain was apparently "worse than
5 ever." The patient had not yet undergone an MRI at that time and Dr. A.F.'s diagnosis was
6 "Unexplained, severe medial leg pain." His plan stated that the patient was going to be "given 15
7 Percocet only," and that the MRI would be reviewed as soon as it is performed and that the
8 patient should obtain an ultrasound of the abdomen.

9 C. The next record is for a follow up visit by J.J. with Dr. A.F., which is dated
10 August 9, 2007. The pain remains severe, and the MRI of the lumbar spine is normal. Dr. A.F.
11 also stated that at that time, he did "not believe [the pain was] orthopedic in nature." He
12 suspected that the patient might have had obturator or femoral nerve injury. He referred the
13 patient to another doctor for evaluation and consideration of a nerve block. Dr. A.F. noted that
14 while the patient would be given a few Percocet, he thought he should try to get off these
15 medications promptly.

16 D. J.J. then went to another doctor for a pain management consultation. He was
17 seen a few times by this doctor, including, on or about August 14, 2007, and September 20, 2007.
18 At the latter visit, it was reported that blocks did not help, and the patient then needed crutches
19 because of pain.

20 E. The next record is for a follow up visit with Dr. A.F., dated October 1, 2007.
21 That record reported that at that time, the pain was in the medial left knee and nerve blocks by the
22 other doctor did not help. Indeed, J.J. reported that he felt that his pain worsened overall. The
23 lumbar MRI scan, however, was negative. The diagnosis was "unknown severe left medial hip
24 pain." The plan was to order an MRI of the pelvis and thigh, along with Percocet.

25 F. The next record is for a follow up visit with Dr. A.F. on October 10, 2007.
26 While the patient could not afford the MRI, X-rays of the hip were essentially normal. The
27 diagnosis is the same. The plan was to inject the hip and prescribe four Percocet.

28 57. A computer generated Initial Pain Management Consultation Report, dated October

1 30, 2007, indicated that J.J. was still numb where the pain was located. The pain was reported as
2 10 out of 10 in severity. The rest of the history was negative. Current medications were
3 Duragesic (fentanyl) patches, OxyContin, Xanax, and Valium. Range of motion of the cervical
4 spine was mildly reduced and of the lumbar spine moderately reduced. J.J. also had an "antalgic"
5 gait (i.e., awkward gait due to pain). Dorsiflexion and plantar flexion of the feet on the left are 1
6 out of 5. Respondent's diagnoses were: 1) Persistent back and leg pain-probable disc injury with
7 discogenic pain syndrome; 2) lumbar radiculopathy; 3) lumbar facet syndrome; 4) depression; 5)
8 motor dysfunction with gait abnormality; 5) anxiety disorder; and 6) sleep disorder. Respondent
9 prescribed OxyContin 80 mg (90 pills), Klonopin 1 mg (90 pills), and ten Duragesic patches to
10 J.J.

11 58. Respondent next saw the patient, on or about November 26, 2007. His record for this
12 date was made on a difficult to decipher preprinted sheet similar to others used by him. In the
13 Patient Information Update form, the patient stated that he was worse, and that his back was
14 hurting more, and his leg was "worse 5/7 days." On that date, Respondent prescribed the
15 following drugs to J.J.: OxyContin 80 mg (120 pills), ten Duragesic patches, and Klonopin 1 mg
16 (90 pills).

17 59. An Upright MRI of the lumbar spine was performed on or about November 28, 2007,
18 which showed no significant pathology.

19 60. Respondent next saw J.J. on or about December 6, 2007. His record for this date was
20 made on a difficult to decipher preprinted sheet similar to those previously used by him. On that
21 day, Respondent prescribed morphine sulfate 60 mg (90 pills), Percocet 10/325 (120 pills), and
22 Baclofen²⁹ 20 mg (90 pills).

23 61. Respondent performed injection procedures on J.J. on or about December 12, 2007.
24 On that same day, he prescribed another ten Duragesic patches to the patient.

25 62. In a Patient Information Update form, dated December 19, 2007, J.J. stated that his

26
27 ²⁹ Baclofen is a muscle relaxer used for treating spasm of skeletal muscles, muscle clonus, rigidity,
28 and pain caused by disorders such as multiple sclerosis. It is also injected into the spinal cord (intrathecal)
for management of severe spasticity.

1 "lower back is doing a little better, but my upper lower back is not doing good, very painful. My
2 leg is still the same." There is no corresponding chart note by Respondent for this visit.

3 Respondent prescribed OxyContin 80 mg (120 pills) and Duragesic patches (100).

4 63. The next record is a neurosurgical consultation summary by Dr. M.S., dated January
5 22, 2008. The report includes findings of pain that require Fentanyl and Oxycodone. He
6 recommended imaging studies.

7 64. On or about January 22, 2008, Respondent prescribed ten Duragesic patches, 75
8 mg/hour, Klonopin 1 mg (90 pills), and OxyContin 80 mg (120 pills). There is no corresponding
9 chart note for this date.

10 65. Respondent next saw J.J. on or about February 11, 2008. His record for this date was
11 made on a difficult to decipher preprinted sheet similar to those previously used by him. In a
12 Patient Information Update form for that visit J.J. said, "Can't sleep because of my back pain. My
13 leg is still the same. My back keeps getting worse." Respondent prescribed ten Duragesic
14 patches, OxyContin 80 mg (120 pills), and Soma 350 mg (120 pills).

15 66. Respondent performed injection procedures on J.J. on or about March 4, 2008. On
16 that same day, he prescribed another ten Duragesic patches, 100 mcg/hour, OxyContin 80 mg
17 (120 pills), and Soma 350 mg (90 pills).

18 67. An Upright MRI of the lumbar spine was performed on or about March 17, 2008,
19 which showed normal results.

20 68. Respondent next saw J.J. on or about March 19, 2008. His record for this date was
21 made on a difficult to decipher preprinted sheet similar to those previously used by him. In a
22 Patient Information Update form for that visit J.J. stated that his pain was getting a little better but
23 he was having more spasms. Respondent prescribed ten Duragesic patches, Klonopin 1 mg (90
24 pills), Xanax 1 mg (90 pills), Kadian³⁰ 10 mg (60 pills), and morphine sulfate 60 mg (60 pills).

25

26 ³⁰ Kadian is a brand name for morphine sulfate extended release capsules. Morphine is in a class
27 of medications called opiate (narcotic) analgesics. Morphine is Schedule II controlled substance pursuant
28 to Health and Safety Code section 11055 (b)(1)(L), and a dangerous drug pursuant to Business and
Professions code section 4022.

1 69. Respondent performed injection procedures on J.J. on or about April 1, 2008.

2 70. Respondent next saw J.J. on or about April 19, 2008. His record for this date was
3 made on a difficult to decipher preprinted sheet similar to those previously used by him.
4 Respondent prescribed Klonopin 1 mg (90 pills), Xanax 1 mg (120 pills), and methadone 10 mg
5 (300 pills). This was the last time J.J. was seen alive.

6 71. J.J. was found deceased in his bedroom, on or about April 25, 2008, when a foul odor
7 was investigated. He was unresponsive and paramedics were called. He had fentanyl patches on
8 his abdomen. His bedroom contained additional fentanyl patches, methadone, morphine,
9 marijuana, and drug paraphernalia. The coroner's report indicated that J.J. had previously been
10 through drug rehabilitation programs but had relapsed several times. The stated cause of death by
11 the Orange County Sherriff Coroner was acute methadone intoxication.

12 72. On and about October 18, 2007, and thereafter, Respondent's record keeping with
13 respect to patient J.J. represents gross negligence.

14 73. On and about October 18, 2007, and thereafter, Respondent was grossly negligent
15 when he failed to adequately assess and treat J.J.

16 74. On and about October 18, 2007, and thereafter, Respondent's prescribing of
17 medications to J.J., as he presented, represents gross negligence.

18 75. On and about October 18, 2007, and thereafter, Respondent was grossly negligent
19 when he prescribed medications to J.J. without a legitimate indication.

20 76. On and about October 18, 2007, and thereafter, Respondent was grossly negligent
21 when he excessively prescribed high-dose opiates and sedatives to J.J.

22 Patient M.H.

23 77. On or about April 22, 2010, Respondent first saw patient M.H., a 24-year-old
24 unemployed man. He had previously been in two motor vehicle accidents. In 2006, while
25 driving, he hit a tree head on and totaled his car. In 2008, he was a passenger in a vehicle that
26 was rear-ended by another car on the freeway. M.H. had a history of six months of physical and
27 chiropractic therapy for his back in 2008, and previously received injections from his pain
28 management doctor. His then current complaints included constant, severe neck, mid back, and

1 low back pain. The pain was 8 out of 10, without medication. The pain was relieved by
2 medication. His current medications included OxyContin, Soma, Roxicodone,³¹ Norco, and
3 Xanax. The patient's Past Medical History and Review of Systems were negative. The records
4 also included a related Initial Pain Management Questionnaire for the patient, which stated that
5 the patient had been taking pain medications (OxyContin) for over three years. Respondent
6 diagnosed M.H. with: 1) thoracic sprain; 2) lumbar sprain/strain; 3) cervical sprain/strain with
7 cervical whiplash syndrome; 4) myofascial pain; 5) opioid dependence; 6) anxiety; and 7) sleep
8 disorder. His plan included an MRI of the lumbar spine, epidural steroid injections in the neck
9 and lumbar spine, physical therapy, chiropractic and laser treatment, and medications, including
10 Oxycontin, Roxicodone, Norco and Xanax. Respondent prescribed OxyContin 80 mg (90 pills),
11 Roxicodone 30 mg (120 pills), and Xanax 2 mg (60 pills). A second prescription, dated April 22,
12 2010, added Norco 10/325 (120 pills), Roxicodone 30 mg (120 pills) and Xanax 2 mg (60 pills).

13 78. Respondent's records for M.H. also contained an unremarkable MRI report of the
14 cervical spine dated February 13, 2009, which showed a 2 mm disc protrusion at C2-3 that was
15 not pressing on any nerves. A handwritten note on the report stated, "not expected in 24 year old
16 patient!"

17 79. Respondent next saw the patient, on or about May 13, 2010. His record for this date
18 included a difficult to decipher preprinted sheet similar to those previously used by Respondent
19 for other patients alleged in this Second Amended Accusation. In the Patient Information Update
20 form, the patient stated that he was working at A-1 Storage. On that date, Respondent prescribed
21 the following drugs to M.H.: OxyContin 80 mg (90 pills), Roxicodone 30 mg (120 pills), Xanax 2
22 mg. (60 pills), and Norco 10/325 mg (120 pills).

23 80. Respondent next saw M.H. on or about June 3, 2010. His record for this date

24
25 ³¹ Roxicodone is a brand name for oxycodone hydrochloride, is a semisynthetic narcotic analgesic
26 with multiple actions qualitatively similar to those of morphine. Oxycodone can produce drug dependence
27 of the morphine type and, therefore, has the potential for being abused. The usual adult dose is one 5 mg
28 tablet every 6 hours as needed for pain. It is a Schedule II controlled substance pursuant to Health and
Safety Code section 11055 (b)(1), and a dangerous drug pursuant to Business and Professions code section
4022. It is also a Schedule II controlled substance as defined by the Code of Federal Regulations Title 21,
section 1308, 12(b)(1).

1 included a difficult to decipher preprinted sheet similar to those previously used by him. His
2 notes stated that the patient was in an auto accident on 5 South on May 28, 2010 and had not
3 received treatment yet. His diagnoses appear to be similar to the first patient visit, but this note
4 also included "opioid tolerance." In a Patient Information Update form for that visit, M.H.
5 reported that his back was hurting very bad and that he got into a car accident few days ago. On
6 that date, Respondent prescribed the following drugs to M.H.: OxyContin 80 mg (90 pills),
7 Roxicodone 30 mg (120 pills), Xanax 2 mg. (60 pills), and Norco 10/325 mg (120 pills).

8 81. Respondent's records include a CURES report, dated June 3, 2010, and covered the
9 period of December 2, 2009, until June 3, 2010. In addition to Respondent, another physician
10 was listed who had prescribed controlled substances to M.H.

11 82. Respondent's next note is a computer generated Initial Pain Management
12 Consultation Report, dated July 1, 2010, that is extremely similar to the April 22, 2010, report.
13 The patient's heart rate and blood pressure were the same on both dates. The Current Complaint
14 section was moved to the top in the July 1, 2010, computer report, and the following sentence was
15 added: "He states he cannot function without medication to control symptoms of pain." The
16 record also includes the following sentence in both reports, "He presented to this office with a
17 MRI from 2-13-09 on disc with no report." However, the July 1, 2010, computer report also
18 included a statement that the February 13, 2009, MRI report was faxed and indicated "multiple
19 levels of cervical and lumbar disc herniations." Respondent also documented the previous
20 diagnosis of "opioid dependence." On that date, Respondent prescribed the following drugs to
21 M.H.: OxyContin 80 mg (90 pills), Roxicodone 30 mg (120 pills), Xanax 2 mg. (60 pills), and
22 Norco 10/325 mg (120 pills).

23 83. Respondent next saw M.H. on or about July 27, 2010. His record for this date was
24 made on a difficult to decipher preprinted sheet similar to those previously used by him. His
25 diagnoses included myofascial pain syndrome and sprain/strain in the cervical, thoracic and
26 lumbar spine. In a Patient Information Update form for that visit, M.H. stated that the patient had
27 been in a lot of pain. On that date, Respondent prescribed the following drugs to M.H.:
28 OxyContin 80 mg (90 pills), Roxicodone 30 mg (120 pills), Xanax 2 mg. (60 pills), and Norco

1 10/325 mg (120 pills).

2 84. Respondent next saw M.H. on or about August 19, 2010. His record for this date
3 included a difficult to decipher preprinted sheet similar to those previously used by Respondent
4 for other patients alleged in this Second Amended Accusation. Respondent also had a
5 computerized Follow-up Pain Management Consultation Report that was very similar to previous
6 reports. The computerized record also included a notation that the patient was referred by another
7 doctor with a history of opioid tolerance; M.H. had been prescribed OxyContin, Xanax,
8 ibuprofen, Norco, and Roxicodone in the past; Respondent's office attempted to wean M.H.'s
9 medications without significant success; and M.H. appeared to be well-intentioned with his desire
10 to reduce medications as suggested. In a Patient Information Update form for that visit M.H.
11 stated that the patient was having very bad pain, ran out of medications, and needed an early refill
12 because he was leaving town. On that date, Respondent prescribed the following drugs to M.H.:
13 OxyContin 80 mg (90 pills), Roxicodone 30 mg (120 pills), Xanax 2 mg. (60 pills), and Norco
14 10/325 mg (120 pills).

15 85. M.H. underwent cervical spine x-rays on or about September 2, 2010, in the Hoag
16 Hospital following a reported injury, with normal results.

17 86. Respondent saw M.H. for the last time on or about October 21, 2010, a few days
18 before his death. His record for this date included a difficult to decipher preprinted sheet similar
19 to those previously used by him. Respondent also had a computerized Follow-up Pain
20 Management Consultation Report that was very similar to previous reports. The computerized
21 record also included a notation that M.H. recently had a fainting episode and was taken to the
22 hospital by his parents, where he was evaluated for potential seizure activity, and that prior to the
23 fainting episode (seizure), M.H. had "removed himself from Xanax." Respondent wrote that
24 M.H.'s "condition appears to have been destabilized by the reformulation of OxyContin
25 medication [and that M.H.] does not wish to take this medication anymore and will be
26 discontinued from it." Respondent further stated that the patient was "counseled about
27 appropriate reduction of medication and will be prescribed Roxicodone, Norco, Xanax only."
28

1 Respondent then prescribed Roxicodone 30 mg (120 pills), Norco 10/325 (120 pills), and Xanax
2 2 mg (60 pills).

3 87. M.H. was found deceased in his bedroom, on or about October 27, 2010, in his
4 mother's house. The report of the Orange County Sherriff Coroner indicated that the deceased's
5 mother had seen him alive the night before, when his father argued with him about his drug abuse
6 and asked him to leave the house; and that M.H. had threatened suicide in the past and his
7 contemporaneous stressors included, money problems over his lost job and a pregnant girlfriend.
8 A syringe and a spoon were at the bedside. The bedroom contained empty bottles of ketamine,
9 Oxycodone, and hydrocodone. Blood and tissue samples contained morphine, codeine, and
10 hydrocodone. The stated cause of death by the Orange County Sherriff Coroner was acute poly
11 drug intoxication due to combined effects of morphine, codeine, diazepam/ nordiazepam,
12 hydrocodone, oxycodone, and alprazolam.

13 88. On and about April 22, 2010, and thereafter, Respondent's record keeping with
14 respect to patient M.H. represents gross negligence.

15 89. On and about April 22, 2010, and thereafter, Respondent was grossly negligent when
16 he failed to adequately assess and treat M.H.

17 90. On and about April 22, 2010, and thereafter, Respondent's prescribing of medications
18 to M.H., as he presented, represents gross negligence.

19 91. On and about April 22, 2010, and thereafter, Respondent was grossly negligent when
20 he prescribed medications to M.H. without a legitimate indication.

21 92. On and about April 22, 2010, and thereafter, Respondent was grossly negligent when
22 he excessively prescribed high-dose opiates and sedatives to M.H.

23 Medical Records.

24 93. Respondent was grossly negligent when he failed to keep adequate and accurate
25 medical records for each of the patients described in this First Cause for Discipline.
26 Respondent's office visit progress notes for each these patients often included the exact same
27 information as in prior notes. His records also contained inconsistencies and inaccurate
28 information.

1 SECOND CAUSE FOR DISCIPLINE

2 (Repeated Negligent Acts)

3 94. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
4 the Code in that Respondent engaged in repeated negligent acts in the care and treatment of
5 patients. The circumstances are as follows:

6 95. The allegations of the First Cause for Discipline are incorporated herein by reference
7 as if fully set forth.

8 96. The allegations of the First Cause for Discipline represent repeated negligent acts.

9 Patient D.O.

10 97. On or about December 1, 2008, Respondent saw patient D.O., a woman who was 19
11 years old, suffering from systemic lupus, with multiple complaints regarding complicated medical
12 and pain management of her current condition. Her initial complaints were pain in her joints and
13 legs, headaches, and trouble with sleep. D.O. was diagnosed with lupus³² at age 13, with central
14 nervous system symptoms and difficulty with walking that was due to cerebral vasculitis. She
15 later developed aseptic meningitis (central nervous system inflammation), seizure, like activity in
16 her legs, and problems with her joints and kidneys. She had a long list of medications and had a
17 history of heavy menstrual bleeding. She required intensive treatment with strong immune
18 suppressant drugs. Although Respondent's note indicated she was also depressed because of her
19 pain and her inability to attend school, her patient questionnaire form indicated that she was not
20 depressed. Respondent's diagnoses were:

21 "1. History of lupus with cerebral vasculitis, 2. History of migraine and cluster headaches
22 with exacerbation after multiple episodes of aseptic meningitis, 3. Probable complex
23 regional pain disorder, 4. Bilateral lower extremity painful peripheral neuropathy, 5. Sleep
24 disorder, 6. Hormone imbalance, 7. History of clotting factor deficiency, and 8. Adrenal
25 deficiency."

26
27 ³² Lupus is a chronic inflammatory disease that occurs when your body's immune system attacks
28 your own tissues and organs. Inflammation caused by lupus can affect many different body systems —
including your joints, skin, kidneys, blood cells, brain, heart and lungs.

1 Respondent's recommendations were as follows:

2 "1. Recommend a diagnostic lumbar MRI study, consider lumbar sympathetic blocks ; 2.
3 Consider a Duragesic [fentanyl] 25 meg patch, Flector patch [anti-inflammatory drug],
4 lidoderm for neuropathic pain; 3. Recommend amitriptyline 10 mg PO HS for sleep
5 disorder; 4. Recommend continuation of Flexeril 10 mg t.i.d. for spasm; 5. Recommend
6 salivary hormone testing and bio-identical hormone replacement as necessary to control
7 bleeding and at the same time replace hormones; 6. Recommend tranquility and satiate for
8 reduction of sympathetically mediated pain; 8. Recommend adrenal gland support with
9 adapt and/or adrenal rebuilder, consider pregnenolone 30 mg po b.i.d.; 9. Encourage regular
10 exercise for weight management and vasculitis/improvement."

11 98. Thereafter, Respondent saw D.O. at least five more times and continued to treat her,
12 including for a hormonal imbalance, without adequate and appropriate consultations with medical
13 specialists such as endocrinologists.

14 99. For example, Respondent saw D.O. again on or about December 8, 2008. D.O. filled
15 out a "Patient Information Update," and wrote as follows:

16 "lupus is flaring up from a respiratory infection. The medication prescribed at my last visit
17 has been very helpful, but I have developed a tolerance. The leg pain is much easier to
18 tolerate with the new patches. I'm not sure if the pain is better, but it hurts less because of
19 the patches."

20 Respondent's typewritten note for this visit essentially appears to be a copy of the prior note, with
21 a few additions. Respondent also wrote,

22 "Additionally, the patient's mother appears to be very obsessed with her daughter's
23 treatment protocols. She may in fact be enabling her daughter with secondary gain in so far
24 as medications without diagnosis in her quest to seek treatment options [sic]. I recommend
25 outside lab diagnostic testing with evaluation by myself for complex hormone rebalancing."

26 A handwritten progress note also included five new diagnoses that appear to be preprinted on the
27 form, but do not seem to pertain to D.O., including, 1) lumbar disc protrusion, 2) lumbar
28 neuralgia, 3) lumbar facet joint pain, 4) sacroiliac joint pain, and 5) rule out right knee

1 arthropathy.

2 100. Laboratory tests from samples dated December 23, 2008, show a low free blood
3 cortisol in the morning and at dinnertime; elevated at noon; and normal at midnight for D.O. In
4 addition, the results also showed that D.O.'s estrogen, other sex hormones and insulin levels were
5 all normal.

6 101. Respondent's next visit with D.O. was on or about December 24, 2008. In the
7 "Patient Information Update" for this visit, D.O. stated that she "developed a very bad kidney
8 infection and bladder infection, doing okay other than that." Similar to the prior note, much of
9 the information on Respondent's typewritten note for this visit is repetitive with the prior note,
10 including the "update" section, provided that the following additional information is included:

11 "She still complains of painful pants, joints, feet, and has difficulty with emotional lability
12 and other hormone dysfunction. Hormone testing has been recommended and the patient
13 has obtained a salivary hormone pack. This patient has been referred to [another doctor] for
14 psychological evaluation. Office contact has been initiated and her appointments with the
15 pain psychologist are pending. Since sleep disorder has not significantly improved, we
16 recommend treatment with amitriptyline 25 mg at bedtime."

17 102. Respondent saw D.O. next on or about January 13, 2009. The following information
18 was included in D.O.'s "Patient Information Update," "Severe migraines. Joint pain is under
19 control . . . Joint pain much better . . . Inflammation also much better." Again, Respondent's
20 typewritten note for the visit is essentially a copy of previous notes with some additional text in
21 places. In the update section, Respondent wrote:

22 "Hormone testing has been completed and is consistent with abnormal cortisol rhythm and
23 burden. This may be construed as a maladapted phase 3. In addition, DHEA was noted to
24 be severely depressed, and supplementation is recommended. 17 hydroxy progesterone was
25 also noted below normal and supplementation was recommended. All hormone testing
26 results and recommendations were reported to patient and mother and eight page diagnostic
27 evaluation with recommendations was provided. Specific proprietary preparations were
28 recommended to the patient for replacement of recommended nutrients/hormones."

1 In the discussion section Respondent wrote, "I will recommend the continuation of methadone 10
2 mg taken twice a day. I recommend acting on the diagnostic testing information and complex
3 hormone rebalancing. . . . Recommended supplements were DHEA, pregnant long [sic], potential
4 Seriphos, and adapt for adrenal fatigue."

5 103. Respondent saw D.O. again on or about February 9, 2009. In the "Patient
6 Information Update," D.O. was noted with a "loss of feeling in feet and increased as well as
7 increased loss of circulation[, and a l]oss of feeling in the left hand[and m]ore frequent pain in
8 knees." Again, Respondent's typed note was very similar to the prior note. His notes regarding
9 hormone testing were included as well. In addition, in the "Current Complaint Update," the
10 patient indicated that methadone was not enough for her pain.

11 104. Respondent last saw D.O. on or about February 23, 2009. In the "Patient Information
12 Update" for this visit, D.O. stated that her feet felt better. Again, Respondent's typewritten note
13 for this visit was essentially the same as the prior visit with minor additions, including the
14 following: "Deactor therapy for treatment of the painful feet has been accomplished with good
15 result. She will continue as necessary." However, prior to this statement are the previous
16 statements, apparently copied from the February 9, 2009 note that are carried over into this note:
17 "loss of feeling in feet and 'increased pain as well as increased loss of circulation.'"

18 105. Respondent was negligent in his care and treatment of patient D.O., including without
19 limitation, when he negligently attempted to address her hormonal imbalance.

20 Medical Records.

21 106. Respondent was negligent when he failed to keep adequate and accurate medical
22 records for each of the patients described in this Second Amended Accusation. Respondent's
23 office visit progress notes for each these patients often included the exact same information as in
24 prior notes. His records also contained inconsistencies and inaccurate information. Furthermore,
25 prescriptions for patients L.Z. and D.O. were not adequately documented in Respondent's
26 medical records for these patients. For example, Respondent failed to adequately document the
27 varying medications taken by L.Z. and D.O., including without limitation, controlled substances,
28 some of which were changed by Respondent without an adequate explanation in the record.

1 **THIRD CAUSE FOR DISCIPLINE**

2 (Incompetence)

3 107. Respondent is subject to disciplinary action under section 2234, subdivision (d), of
4 the Code in that Respondent was incompetent in the care and treatment of patients. The
5 circumstances are as follows:

6 108. The allegations of the First and Second Causes for Discipline are incorporated herein
7 by reference as if fully set forth.

8 **FOURTH CAUSE FOR DISCIPLINE**

9 (Failure to Maintain Adequate/Accurate Medical Records)

10 109. Respondent is subject to disciplinary action under section 2266 of the Code, in that
11 Respondent failed to keep adequate and accurate records related to the provision of medical
12 services to patients. The circumstances are as follows:

13 110. The allegations of the First, Second and Third Causes for Discipline are incorporated
14 herein by reference as if fully set forth.

15 **FIFTH CAUSE FOR DISCIPLINE**

16 (Excessive Prescribing)

17 111. Respondent is subject to disciplinary action under section 725 of the Code in that
18 Respondent clearly excessively prescribed narcotic medications to patients. The circumstances
19 are as follows:

20 112. The allegations of the First, Second, Third and Fourth Causes for Discipline are
21 incorporated herein by reference as if fully set forth.

22 **SIXTH CAUSE FOR DISCIPLINE**

23 (Violation of Drug Statute)

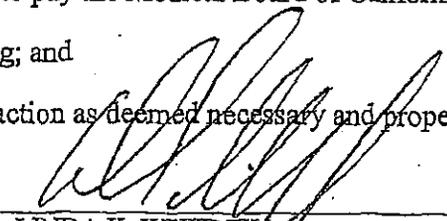
24 113. Respondent is subject to disciplinary action under section 2238 of the Code and
25 11190 of the Health and Safety Code in that Respondent failed to make a record of his
26 prescriptions to his patients for controlled substances. The circumstances are as follows:

27 114. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline are
28 incorporated herein by reference as if fully set forth.

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- 3. Ordering John Petraglia, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and
- 4. Taking such other and further action as deemed necessary and proper.

DATED: February 14, 2013



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

LA2011500798
60937787.doc