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

In the Matter of the Accusation Against:	)	
	)	
	)	
RAY POON-PHANG SEET, M.D.	)	**Case No. 12-2008-190960**
	)	
	)	**OAH No. 2013010112**
Physician's and Surgeon's Certificate No. G 20523	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Proposed Decision is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on September 13, 2013.

IT IS SO ORDERED August 15, 2013.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD

Dev Gnanadev, M.D., Chair
Panel B

PLAINTIFF TRIAL EXHIBIT
P-27609_00001

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

In the Matter of the Accusation Against:	
RAY POON-PHANG SEET, M.D.,	Case No. 12-2008-190960
Physician and Surgeon's Certificate No. G 20523,	OAH No. 2013010112
Respondent.	

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California, on June 3, 4, 5, and 6, 2013.

Brenda Reyes and Lynne K. Dombrowski, Deputy Attorneys General, represented complainant.

Respondent Ray Poon-Phang Seet, M.D. was present and unrepresented.

The matter was submitted on June 6, 2013.

FACTUAL FINDINGS

1. Complainant Linda K. Whitney made this accusation in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On June 9, 1971, Physician and Surgeon's Certificate No. G 20523 was issued by the Board to Ray Poon-Phang Seet, M.D. (respondent). Respondent's certificate is renewed and current, and will expire on November 30, 2013.

Prior disciplinary action was taken against respondent as follows: On February 23, 1996, a Decision became effective which revoked respondent's certificate. The revocation was stayed and respondent was placed on probation for five years with terms and conditions. On May 7, 2001, another Decision became effective which revoked respondent's certificate, stayed the revocation and continued the probation to December 31, 2001. On December 24, 2001, a Petition to Revoke Probation was filed. On May 19, 2003, a Decision became

effective, which revoked respondent's certificate. The revocation was stayed and respondent was placed on probation for a period of two years. On January 1, 2004, probation was completed and respondent's certificate was fully restored.

3. A list of relevant medications is in the accusation beginning on page 5, line 18 and ending on page 14, line 4. That list is incorporated in this decision as if fully set forth herein. It should be noted that Oxycodone, Vicodin and Norco all contain acetaminophen in varying amounts as set forth in this list.

Gross Negligence/Negligence/Incompetence – Patient H.A.

4. On September 29, 2006, patient H.A., a 91-year-old male, was admitted to Marin General Hospital after a fall at his assisted living facility. During his hospitalization, H.A. became agitated and was managed with Risperdal and Ativan and diagnosed with "dementia with agitation." H.A. had been hospitalized for five days when he was transferred to Pine Ridge Care Center on October 3, 2006. The Marin General transfer note to Pine Ridge listed pertinent diagnoses as dementia, B12 deficiency, hypertension, and hypothyroid and recommended that H.A.'s activity be supervised. Marin General included H.A.'s admitting history and physical with its transfer report. The history and physical made no mention of alcoholism and in fact stated in the social history portion that H.A. had never been a heavy drinker or even a significant social drinker. It also noted that H.A. was dehydrated according to admitting laboratory results. The transfer report noted that H.A. was an aspiration risk. Respondent was in charge of H.A.'s care at Pine Ridge and was aware that Marin General recommended that H.A. have a "sitter." H.A.'s daughter held a Durable Power of Attorney for Health Care for him. On admission to Pine Ridge, H.A. was agitated and at times combative, but alert and responsive.

5. Respondent first saw H.A. on October 5, 2006. His admitting history and physical is very brief and partially illegible. Respondent documents H.A.'s history as including "multiple falls, [illegible word] tremors/ataxia, noted confabulation, tangential ideation, lives alone, hypothyroidism, ? head injury." The diagnosis section states, "ataxia/tremor, prob. chr alcoholism c U/E ecchym & shin tear."

6. H.A.'s primary care physician had prescribed psychoactive medications for agitation which were administered by Marin General before transfer to Pine Ridge, which medications were Ativan, Restoril and Risperdal. Although Pine Ridge prepared informed consent forms to take these medications, these were not signed by his daughter. During H.A.'s stay at Pine Ridge, no further informed consent for psychoactive medication was obtained. H.A. was not assigned a "sitter" until his last days at Pine Ridge.

7. On October 5, 2006, H.A. was also seen by a psychiatric nurse practitioner, who noted H.A.'s agitation and combativeness. She concluded that H.A. suffered from alcohol-induced persistent dementia, cerebral degeneration. Organic affective syndrome, and dementia with behavioral disturbance. The psychiatric nurse practitioner had a telephone consultation with her supervising psychiatrist, who recommended discontinuing Restoril and

Ativan and beginning Librium 100 mg every 6 hours for 24 hours, then 75 mg every six hours for two days, then 50 mg every 6 hours for one week. Respondent approved this regimen for treatment of H.A.'s alcohol withdrawal. However, respondent did not specifically discontinue H.A.'s Restoril or Ativan.

8. H.A. became increasingly sedated on his medication regimen at Pine Ridge, and his daughter expressed concern over his sedation and was told that it was treatment for H.A.'s alcohol withdrawal. The daughter asked that the medications be discontinued because her father had never been an alcoholic or even a heavy drinker. Respondent spoke to the daughter on October 9, 2006, and she demanded that all sedating medications be stopped, but respondent indicated they were necessary for detoxification from alcohol. Respondent only indicated that he would reevaluate H.A.

9. Respondent saw H.A. on October 10, 2006. The nursing notes indicated that H.A. was sleepy, but cooperative with only one episode of agitation in the morning. Nursing notes indicate that one hour after that notation, respondent increased H.A.'s Librium to 50 mg four times a day despite of the daughter's request and his own observations that H.A. was "awake with arousal" and "sedated." Respondent also noted that the daughter wanted medication at the lowest level to do the work. With no documented reason, on October 12, 2006, respondent decreased the Librium from 50 mg four times a day to 25 mg three times a day.

10. On October 14, 2006, the patient's daughter contacted respondent and indicated the H.A. was not eating, that he was having trouble swallowing, and the he seemed dehydrated. Respondent saw H.A. on October 14, 2006, and noted that H.A. was "arousable, eyes closed" and "dehydrated." Respondent did not document any assessment of swallowing or gag reflex. Respondent ordered staff to "give fluid juice/water continuously" and "that staff could use tracheal suction for tracheal mucus." Staff successfully administered 300 cc of water by mouth.

11. By the morning of October 15, 2006, H.A. was unresponsive. He had a high fever and very low oxygen saturation. He was transferred to Marin General Hospital where he was treated for aspiration pneumonia and altered mental status. Although respondent gave a telephone order for H.A.'s transport to Marin General on a nursing report that H.A. could not be aroused, there is no indication that respondent ordered transportation to the hospital on any Pine Ridge treatment notes or prepared a summary of care to be sent to Marin General on transfer. H.A. made no significant recovery and died in the hospital on November 8, 2006. Urine testing for Librium and it metabolites remained positive for two weeks into his hospitalization, and an initial EEG suggested metabolic slowing.

12. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted gross negligence, repeated acts of negligence, and incompetence in his care and treatment of patient H.A. in that respondent failed to review, note, and understand the medical information provided by Marin General Hospital on H.A.'s transfer to Pine Ridge on October 3, 2006, as part of his initial evaluation

of H.A., and he failed to provide his own clinical information on H.A. when he ordered him transferred back to Marin General Hospital on October 15, 2006.

13. Respondent diagnosed H.A. with chronic alcoholism on observation of ataxia, confabulation, and tangential ideation, without review or understanding of the transfer papers from Marin General, which indicated very limited alcohol intake, and without assessment or examination for acute alcohol withdrawal. The patient had been hospitalized for approximately seven days prior to being seen by respondent for the first time. It is extremely unlikely that the patient consumed alcohol during his hospitalization. Respondent also failed to note that the symptoms could be indicative of many other disorders; that the patient's pulse and blood pressure were normal on transfer (which would not have been the case if he were in alcohol withdrawal); and that the symptoms noted did not begin on admission to Pine Ridge, but were observed, diagnosed, and treated at the hospital before transfer. Respondent did not understand that confabulation is not a symptom of alcohol withdrawal.

14. Respondent prescribed Librium in tapering doses for H.A.'s alcohol withdrawal syndrome when he had no basis for the diagnosis, when the patient's daughter indicated, as did hospital records, that H.A. hardly drank alcohol at all, and when he knew or should have known that high doses of Librium in a 91-year-old man is dangerous. Respondent lacked knowledge or ability in the correct diagnosis of alcohol withdrawal syndrome and in the potential consequences of treating an elderly non-alcoholic with a regimen of Librium that is only recommended for alcohol withdrawal.

15. Respondent failed to use psychotropic medication in a skilled nursing facility setting only when necessary for a specific condition, in the lowest dose, and after obtaining informed consent. There was no informed consent for the use of Librium on H.A.'s chart or in H.A.'s file at Pine Ridge or any indication of a discussion with the patient's daughter regarding its purpose or her right to refuse treatment on behalf of her father. Respondent failed to consider behavioral interventions and efforts to discontinue the drug even when indicated by H.A.'s excessive sedation and the fact that indications were that H.A. was not suffering from acute alcohol withdrawal.

16. Respondent continued to use high doses of Librium in face of multiple observations that the patient was sedated. In the face of nursing notes, physical and occupational therapy notes, and respondent's own notes that H.A. was heavily sedated, as well as the patient's daughter's repeated complaints that her father was overmedicated, respondent did not stop the use of Librium, even increasing the dosage in one instance directly after the daughter requested that the medication be stopped.

17. Respondent ordered oral fluids to be administered to H.A. on October 14, 2006, in spite of the fact that H.A. had to be roused to a wakeful state and the fact that the patient's daughter had informed respondent that H.A. could not eat and was having trouble swallowing. Respondent failed to assess H.A.'s ability to swallow and to protect his airway before ordering fluids to correct his dehydrated state by oral administration of liquids.

Respondent failed to appreciate that administration of 300 cc of fluid in one shift was grossly inadequate to correct dehydration in any case.

Prescribing Without Examination/Medical Indication - Patient H.A.

18. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted prescribing without examination and medical indication in violation of the law. Respondent prescribed Librium for H.A. without appropriate prior examination and medical indication. Respondent diagnosed H.A. with acute alcohol withdrawal and prescribed high doses of Librium appropriate only for the treatment of acute alcohol withdrawal without first consulting the transfer records from Marin General Hospital, without examining H.A. to rule out other causes for the patient's ataxia, tremors, dementia, and confabulation and confirm his diagnosis, and without carefully considering the dosages that were appropriate for this patient's advanced age.

Inadequate/Inaccurate Records-Patient H.A.

19. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted unprofessional conduct in that respondent's records for H.A. were inadequate and inaccurate. Respondent's records for H.A. are generally illegible and are significantly inaccurate in relation to his social history. There was nothing in H.A.'s transfer records to suggest alcoholism, and the patient's daughter insisted that her father had no history of excessive drinking. Respondent's diagnosis of "chronic alcoholism" was picked up by him from the behavioral medicine nurse practitioner and used as the basis for a treatment recommendation using levels of Librium that would only be used in the setting of acute alcohol withdrawal. Respondent had the opportunity to seek corroboration of this diagnosis, but he declined to revisit it and persisted in basing his treatment on his original erroneous diagnosis.

Gross Negligence/Negligence/Incompetence - Patient M.B.

20. From 2006 through 2008, respondent was the medical director of Country Villa San Rafael skilled nursing facility (formerly Hillside Care Center). Respondent was also a house physician, acting as primary care physician for a portion of the residents. As director, he assumed care for indigent patients. One of his patients was M.B., a long-term female resident with both mental and physical disabilities; M.B. was 57 years of age in 2007. M.B.'s physical disabilities were the result of multiple major fractures sustained in a suicide attempt and a seizure disorder which developed after the removal of a benign brain tumor in 1985. M.B. also had a number of psychiatric diagnoses, including conversion reaction, schizophrenia, bipolar disorder, and depression. For M.B.'s chronic intractable pain resulting from her fractures, respondent prescribed Oxycontin 40 mg bid and Vicodin as needed for breakthrough pain.

21. On June 5, 2007, M.B. had a psychotic episode ad was transferred to Marin County Psychiatric Emergency, which placed M.B. on a 72-hour hold. While there, M.B.

fell and broke her left leg and was admitted to Alta Bates Hospital, where she was found to have a mid-shaft tibia/fibula fracture, as well as extensive diffuse osteopenia. On June 7, 2007, a closed reduction of the fracture was performed, and she was placed in a patellar tendon bearing cast. It was noted that M.B. had an intramedullary rod in the left femur with four distal fixation screws from an earlier injury. The discharge summary indicated that her weight-bearing status was touchdown weight-bearing to the left lower extremity and gradually increasing. She was to follow-up with the orthopedic surgeon at his office.

22. On June 8, 2007, M.B. was transferred to the Herrick Hospital psychiatric unit, where she remained until June 25, 2007. The admission note indicated M.B. had previous bilateral knee surgery and bilateral wrist surgery related to jumping episodes or previous suicide attempts. She was evaluated by physical therapy. M.B. was found to be somnolent on the level of Oxycontin prescribed by respondent, so this was reduced to 20 mg bid and then held entirely due to somnolence. The Discharge summary from the psychiatric unit indicated M.B. was to remain on non-weight-bearing status and follow up with the orthopedist within 30 days post discharge. It indicates her mental diagnoses on discharge were "Axis I, schizoaffective disorder, depressed, r/o factitious disorder, Axis II, borderline personality disorder."

23. On June 25, 2007, M.B. was readmitted to Country Villa, and respondent reassumed responsibility for her care as her primary care physician. On June 26, 2007, respondent entered an admitting note indicating her return to the facility, but the note makes no mention of the cast. Respondent's assessment was "Much weight decreased with cachexia, chronic pain sx, recent colles fracture, multiple trauma, depression, psychosis." A colles fracture is a fracture of the wrist not the leg. Respondent's plan for treatment consisted of "cont. all pain and psychotropic drugs" written in the margin. He does not mention nor have any plan for the Foley catheter that M.B. had in place on transfer; his examination of the genitalia is noted as "atrophic" with no mention of a catheter in place. Respondent presented no therapeutic plan for dealing with M.B.'s cachexia and weight loss, although five weeks later, he did order Megace Es for cachexia.

24. There are no Physician's progress notes for M.B. from April 24, 2007 to November 27, 2007. On November 28, 2008, respondent wrote "Interval General Medical Note" in which he says his progress notes have not been found, but reiterates dates on which nursing notes appear to indicate he saw M.B. On November 20, 2007, the Department of Public Health issued a citation to the facility for delayed removal of M.B.'s cast. The "interval General Medical Note" was made eight days after the citation was issued. Respondent claimed (at an interview with the Board) that an appointment was made for M.B. to see the orthopedic surgeon in early July but that she refused to go. He also stated that he referred the patient to local orthopedists for follow up, but that they refused to see her due to her Medi-Cal status. There is no notation on the patient's records either by respondent, in nursing notes, in social service staff notes or any other record for the patient that these referrals were made. Respondent stated at his physician conference with the Board on September 14, 2009, that he had removed the cast himself on November 6, 2007, but there is no confirmation of this action in the patient's medical records. There is only a notation in the

social service notes that M.B. had refused to go to an appointment for cast removal scheduled with an orthopedic surgeon on November 6, 2007, and that respondent had removed the cast himself on that date.

25. During the seven-month-period for which respondent had no physician's progress notes for M.B., nursing notes indicated respondent's activities with respondent to M.B. as: May 19, 2007 – "in the facility with new order"; June 4, 2007 – "came and informed resident sent to hospital for resident psychotic behavior"; June 26, 2007 – "seen by Dr. Seet"; August 19, 2007 – "Dr. Seet made visit with new orders"; August 26, 2007 – "Dr. Seet here ordered psych eval"; September 26, 2007 – "Dr. Seet came with new order of treatment"; October 14, 2007 – "Dr. Seet has come by today and undersigned [illegible] referral about resident's L lower cast. Dr. Seet has seen and talked to resident and noted order for discontinuing order for Vicodin . . . and ordered to make an appointment with ortho surgeon for removal of L leg short cast." There are no nursing notes in M.B.'s records between the October 14th note and November 9, 2007.

26. There is a fax request from nursing to Dr. Seet in the record dated September 3, 2007, in which a nurse requested an orthopedic consult. Respondent answered in the affirmative to this request. However, there is no notation prior to October 14, 2007, of any affirmative order by respondent for an orthopedic surgeon to remove the cast. There is no notation in the record of any plan by respondent for the evaluation of the patient's healing fracture, interim care, and timely removal of the cast with follow up evaluation and physical therapy.

27. After removal of M.B.'s cast by respondent on November 6, 2007, radiological studies to evaluate healing of the fracture were not ordered until November 25, 2007, and it is unclear who ordered the x-rays.

28. During the seven months for which there are no physician's notes, physician's orders indicate respondent prescribed topical antibiotics for a 2 cm abscess of her thigh, and in early November 2007, when the patient had a sty, respondent prescribed Maxitrol drops. After readmission, respondent again increased the amount of narcotics given to M.B. without documenting any examination, reason of the increase, or response to therapy.

29. During his physician conference with the Board on September 14, 2009, respondent stated that part of his role as medical director of County Villa was to call or write doctors if they failed to see their patients and to see the "indigent" patients. When asked if he agreed with the Department of Public Health that a medical director is "responsible for patient care policy and coordination of care," respondent replied, "They don't pay me enough for that." As to M.B., respondent stated that her records came with her from the hospital and acknowledged that he never spoke with the orthopedist who had set the patient's leg fracture, and stated that he reviewed her records and saw her for up to 25 minutes and encouraged her to take her medications. He described his treatment plan as "supportive care." He claimed that admitting orders are "pre-written" and the he just signed them. He acknowledged that the discharge summary specified orthopedic follow up with the

orthopedist who set her leg fracture, but that he did not write an order for that because he expected social work and nursing to do that. When respondent was asked about why he did not document anything concerning the patient's cast or a plan of care for it on his admitting note, respondent replied that he thought he was overwhelmed because the patient had so many other issues.

30. When informed that he was under investigation by the Board for his care and treatment of M.B., respondent had M.B. (a severely mentally disabled person dependent upon him for care) write a witnessed letter of support on his letterhead dated June 21, 2009. In her own handwriting, she discussed her medical condition, respondent's medical care for her, and the fact that she wanted to keep respondent as her doctor.

31. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted gross negligence, repeated acts of negligence, and incompetence in that he failed to consult with the orthopedist who repaired M.B.'s leg fracture to coordinate necessary follow up care and to implement the care plan established by the specialist. This is not the province of nursing or social work, but the responsibility of the primary care physician. When (if) the patient refused follow up orthopedic care, there is no documentation of any discussion with the patient as to the risks of refusing care, and there is no indication that the orthopedist was consulted as to possible alternatives such as x-rays taken at a closer facility and delivered to the orthopedist to determine timing as to when to remove the cast. After removing the cast, respondent did not consult with the orthopedist and did not arrange for timely follow-up x-rays and assessment. Respondent's failure to coordinate care for M.B.'s leg fracture, his statement that he was not paid enough to coordinate this patient's care, and failure to take responsibility for her remaining in a cast for five months constitute unprofessional conduct and an extreme departure from the standard of practice of medicine.

32. Further, respondent prescribed Megace for M.B.'s cachexia. There is no indication of any work up to determine the cause of the weight loss and initiation of treatment based upon the cause. Megace is generally reserved for patients with wasting from AIDS or cancer.

33. M.B. was readmitted to the facility with a Foley catheter in place. Respondent failed to note this, and failed to assess the patient for removal as soon as possible to reduce the risk of infection. The catheter was not removed for four weeks, and then only upon the patient's request.

34. Respondent failed to document an examination and evaluation when prescribing and altering the amount of narcotic pain medication prescribed to M.B. for pain.

35. Respondent failed to assess M.B. and determine whether incision and drainage or systemic antibiotics were necessary to treat her thigh abscess. Application of topical antibiotics is not indicated for the treatment of infected cysts or abscesses.

36. Respondent prescribed Maxitrol for M.B.'s sty based on a telephone description of her problem. Maxitrol contains steroids and antibiotics, and the steroid carries the risk of exacerbating some eye conditions and should not be used unless the eye has been examined and the diagnosis requires it.

37. M.B. was mentally disabled and remained respondent's patient when respondent asked her to write a letter of support for him to help in the investigation against him. It is inappropriate to ask any patient to write such a letter in this context, but it is grossly unprofessional to have asked a patient with the mental conditions of M.B. to do so. Respondent blurred the boundaries between physician and patient when M.B. had severe challenges in maintaining appropriate boundaries as a result of her diagnosis of borderline personality disorder.

Prescribing Without Examination/Medical Indication – Patient M.B.

38. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted prescribing without examination and medical indication in violation of the law. Respondent prescribed Megace for M.B.'s cachexia without work up as to the cause of the weight loss or indication for the use of a medication generally reserved for AIDS and cancer patients.

39. Respondent increased the amount of M.B's narcoticprescriptions for her chronic pain without documentation of any examination, assessment or indication for the increase and without any follow up assessment of therapeutic effect.

40. Respondent prescribed Maxitrol for M.B.'s sty without first examining the eye and diagnosing the exact condition of the eye before determining that a medication containing steroids was indicated.

Inaccurate/Inadequate Records – M.B.

41. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted unprofessional conduct in that respondent's records for M.B were inaccurate and inadequate. There are no physician's progress notes in the patient's records between late April and early November 2007. There is no corroborating evidence in other notes in the record that monthly visits were made to the patient or that respondent paid any attention to her leg cast before October of 2007. Respondent claims that his progress notes for this period were lost and bases his summary of care, entered on November 28, 2007, on nurses' notes during that period. The nurses' notes that mention respondent, only indicate that he saw M.B. two or three times.

42. Respondent's admission note for June 26, 2007, is inaccurate. It makes no note of M.B.'s leg cast and in fact states that she has a "colles" fracture, when is a fracture of the wrist. Respondent's psychiatric diagnoses for M.B. on admission do not correlate in any

way with the discharge diagnoses on the transfer summary from the psychiatric hospital. There is no mention of the Foley catheter in place in his examination of the patient.

Gross Negligence/Negligence/Incompetence – Patient M.H.

43. On October 6, 2009, M.H., a 22 year old male, consulted Respondent. No reason for the visit to respondent is noted. The patient had a regular pain physician. There was no notation that the patient had been referred to respondent. The patient was experiencing continuing pain after left-shoulder arthroscopic surgery and development of left shoulder arthritis and the development of a paralabral cyst and associated tearing of the labrum in his right shoulder. M.H. indicated he was taking methadone for the pain and that he would like to up his dose of methadone because he was still experiencing pain; he indicated decreased overall function due to pain. He described his pain as 8-9/10 in intensity, with the least pain experienced as 5/10. His blood pressure and pulse were normal. M.H. completed a medical pain history and list of medications he was currently taking. He listed his current medication as methadone, 10 mg, four times or more daily, and past medications as naproxen, aspirin, ibuprofen, Percocet, Darvocet, and Oxycontin. Respondent performed a physical examination. Respondent prescribed tramadol 50 mg one to two bid; gabapentin 60 mg one to two at bedtime for seven days, and bid for pain block; and methadone 10 mg two every six to eight hours.

44. Respondent next saw M.H. on October 19, 2009. A history was taken and a physical performed. Respondent noted a goal as four to five methadone tablets a day. Blood pressure and pulse were taken and were normal. Pain was described as reduced to 2-3/10. Respondent prescribed methadone 10 mg, two every eight hours; tramadol 50 mg, one every eight hours; and added Norco 10/325, one every six hours. There was no notation as to why Norco was added.

45. Respondent next saw M.H. on November 3, 2009. Respondent noted a goal to decrease methadone to 40 mg per day from the 60 to 70 mg M.H. was taking. A brief physical examination was done. Pain remained decreased in intensity. A urine drug screen was ordered. M.H. tested positive for methadone and tramadol, as well as oxycodone and oxymorphone. M.H. explained the oxycodone/oxymorphone results because he was taking the drugs prescribed by another physician. At a December 3, 2009, appointment, M.H. indicated that he took Percocet when he ran out of methadone at five per day. Respondent prescribed methadone 10 mg, two every eight to nine hours and gabapentin 600 mg, one to two every eight hours.

46. Respondent saw M.H. on December 3, 2009. Pain was noted at 2/10. Noted were decreased range of motion, crepitus, and other motor findings with regard to M.H.'s shoulder. The results of the urine drug screen were reviewed. Respondent did not inquire further about M.H.'s use of drugs prescribed by another physician and did not contact that physician. Respondent prescribed methadone 10 mg one every four to six hours; tramadol 50 mg one every eight hours for breakthrough pain; and Norco 10/325, every eight hours for breakthrough pain.

47. Respondent saw M.H. again on January 4, 2010. Pain was noted as 4.5/10. Respondent prescribed methadone 10 mg one every four to six hours and gabapentin 600 mg [instructions unclear]. There is a notation in the chart that M.H.'s mother called on January 20, 2011 and informed respondent that M.H. "took too much meds." M. H. had overdosed on drugs and had to be hospitalized. Respondent noted at the bottom of the January 4, 2010 progress notes, "D/C from clinic. Cover for emergency."

48. Respondent did not see M.H. again until January 26, 2011, when the patient indicated on his patient registration form that he had been taking street heroin and oxycodone. No reason for the visit was entered. M.H. signed a pain medication agreement, and a Clinical Opiate Withdrawal Scale (COWS) was done, with a final score of 6 (mild withdrawal symptoms). M.H. noted that he had been treated at Mountain Vista Farms in February/March 2010. Respondent took no history of the year interval since he had last seen M.H., so no information was obtained concerning his treatment program and its outcome, of other treatment programs, other attempts at drug withdrawal, other illicit drugs used besides heroin, and any hospital stays. Medical progress notes by respondent indicated present illness as right shoulder pain with pain now 1.5/10 and past history as "dependent on narcotics s/p arthro surg 10/10." Respondent diagnosed stable right shoulder pain and narcotic dependence. Respondent prescribed Suboxone, one to two every eight hours, with follow up in two weeks. There was no follow up visit recorded.

49. At no time during his treatment of M.H. did respondent obtain a release of information authorization to obtain medical records from previous or concurrent physicians, contact the patient's previous or concurrent physicians, or search the CURES (Controlled Substance Utilization and Evaluation Program) program for information related to pervious or concurrent controlled substance prescriptions of this patient. At no time during his treatment of M.H. did respondent warn the patient of the cardiac danger of methadone or do any tests to check for heart damage. At no time during his treatment of this patient did respondent obtain information from his previous or concurrent physicians concerning previous EKG's they may have performed.

50. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted gross negligence, repeated acts of negligence, and incompetence in that he failed to take an adequate history and performed an inadequate physical examination before prescribing controlled substances for pain. He did not include physical and psychological function, substance abuse history, history of prior pain management, or assessment of the underlying or coexisting disease or condition.

51. Respondent's treatment plan did not include objective measurements by which treatment goals could be evaluated, such as improvement of psychological and physical function, and did not include plans for any further diagnostic evaluations or treatment. He did not tailor M.H.s treatment to the patient's individual medical condition.

52. Respondent failed to obtain a release of information for M.H.'s prior or concurrent treating physicians. He failed to contact M.H.'s previous or concurrent treating physicians to obtain treatment information or consult or coordinate with them. Respondent did not consult CURES for information concerning previous or concurrent controlled substance prescriptions for the patient, even when the patient informed respondent he was taking controlled substances prescribed by other physicians when methadone was not adequate to control his pain.

53. Respondent repeatedly prescribed methadone for M.H. without warning him of the potential health consequences associated with its use or following FDA guideline and did not monitor M.H. appropriately for potential complications. He failed to provide M.H. with an informed consent regarding potential side effects of methadone, including sleep apnea, testosterone insufficiency, cardiac arrhythmias, and addiction.

54. After more than a year had passed since respondent saw M.H., respondent prescribed Suboxone as an opioid maintenance program for a patient with an addiction problem. Respondent failed to take an interim addiction history or an interim drug treatment history, and he did not document any discussion as to why Suboxone maintenance was indicated. There was no documentation of an addiction problem in M.H.'s treatment records.

Gross Negligence/Negligence/Incompetence – Patient J.B.

55. J.B. is a female adult approximately 27 years old in 2004/2005. In 2004, J.B. was convicted of passing false checks, a felony, and she was sentenced to three years' probation. In 2005, she was convicted of being under the influence of a controlled substance, methamphetamine, a misdemeanor, and sentenced to two years' probation.

56. In mid-2005, J.B. relocated to Marin County from Santa Clara County. She became respondent's patient. In March of 2007, J.B. and respondent were married. Respondent and J.B. resided at the same address in Novato, California at all times pertinent to the facts set forth herein.

57. In May of 2008, J.B. was arrested by the Novato Police Department for driving under the influence of alcohol. J.B. had lost control of her vehicle and crashed into the home of a neighbor across the street and had run into her own home. When police entered the Seet residence, J.B. was there, as well as her passenger and other residents at her home address. J.B. failed field sobriety tests. She was arrested and charged with driving under the influence, hit and run, and in August of 2008 in Marin County Superior Court, J.B. was convicted of driving under the influence, a misdemeanor and sentenced to 36 months probation. Her driver's license was suspended.

58. In October of 2008, an anonymous tip was called into the Petaluma Police Department indicating the J.B. was selling narcotics out of her place of work, a hair salon. A police officer observed what appeared to be a drug sale outside the salon. He followed the purchaser in his vehicle. The officer stopped the vehicle for a routine equipment violation,

and J.B. was the driver of the vehicle. J.B. was arrested for driving with a suspended license and giving false information to a police officer. A search revealed a bag containing drug paraphernalia, marijuana, and a baggie containing what was later confirmed to be methamphetamine. J.B. was booked for possession for sale, and transportation of methamphetamine. A felony complaint was filed against J.B. based on these charges.

59. In November of 2008, J.B. was arrested at her residence for being under the influence of a controlled substance, methamphetamine. A search warrant was executed at J.B. and respondent's home on suspicion of possession of controlled substances for sale. At the residence the police discovered drug paraphernalia, a number of "pay/owe" slips in the names of various persons, and evidence of methamphetamine use. An arrest warrant was issued late December 2008, and in March 2009, in a negotiated plea, J.B. pled guilty to a violation of Health and Safety Code section 11377, subdivision (a) (unlawful possession of a controlled substance), a felony. In April 2009, J.B. was sentenced to 36 months formal probation with terms that included a program of treatment to be served in a recovery program in Petaluma, counseling, registering as a narcotics offender, DNA testing, and warrantless searches. In July of 2009, J.B.'s probation was summarily revoked, and she was taken into custody. At a probation hearing, J.B. was released to Marin County Probation for placement in a residential treatment program when space became available. In the interim, J.B. was to remain in custody. In August, 2010, J.B. was released from custody to be transported to a treatment facility.

60. Prior to the incidents set forth in Finding 53, above, J.B. was found in possession of illegal paraphernalia and found to have failed "first treatment." In November of 2009, J.B. tested positive for amphetamine in a random drug screening. In January of 2010, during a probation search at her Novato home, J.B. was found in possession of marijuana. J.B. produced a medical marijuana card issued by respondent, her husband, who was present. In January 2010, a further petition to revoke probation was filed. A hearing was held in March 2010, where the petition was dismissed and J.B. was order to remain in the treatment program and be subject to random testing.

61. In June 2010, another petition to revoke probation was filed based on J.B.'s second treatment failure. In August 2010, while J.B. was in custody, she was ordered to report to probation on release from Sonoma County and provide the Marin County court with an assessment report.

62. A further petition to revoke probation was filed in Marin County in July 2010 based on a third treatment failure, a drug-related violation. At the time of filing, J.B. was in custody in Sonoma County. In July 2010, during a probation search at her home, she was found in possession of methamphetamine and drug paraphernalia. Respondent was present. J.B. was ordered by Marin County to go into the residential treatment program arranged by Sonoma County probation or be terminated from the Proposition 36 program. In September 2010, probation was reinstated, and J.B. was again ordered into treatment.

Respondent's Treatment of Patient J.B. - 2005

63. On May 20, 2005, respondent began treating J.B. as a patient. She filled out a new patient form and submitted some medical records. Her medical history included recurrent headaches and a diagnosis of attention deficit hyperactivity disorder (ADHD) for which Adderall had been prescribed at a clinic beginning in 1995 and ending in 1999. After 1999, J.B. was prescribed Ritalin and Paxil until 2001. Respondent prescribed Imitrex and Adderall at this first visit. No examination or testing for migraine headaches or adult ADHD or referral to an appropriate specialist is noted in respondent's records for this patient. Shortly after this first appointment, respondent and J.B. began residing together at his home in Novato.

64. Respondent inserted into J.B.'s medical record an undated letter on his letterhead address To Whom It May Concern, stating the J.B. is on Adderall and her urine will be positive for amphetamines if tested. A summary of patient history dated June 29, 2005, was provided to the Women's Correctional Facility in San Jose indicating that J.B. has a long standing history of ADHD and that she needs Adderall to function. Respondent had knowledge of J.B.'s arrest and conviction record for drug-related offenses.

65. According to respondent's records, J.B.'s next office visit was on September 8, 2005. She had gained weight and it is noted that the Women's Correctional Facility discontinued her Adderall. Respondent prescribed Adderall and Xenical. A summary of patient history was sent to Santa Clara Medical Facility on October 2, 2005, for no specified reason. In December 2005, a letter from Bayside Marin indicates that respondent was inquiring into sober living environments for J.B.

2006

66. J.B.'s next office was January 9, 2006. She was 21 years old in 2006. She filled out a new patient form. Respondent indicated in the patient's history that she had ADHD and had been on Adderall for four years and on Ritalin since childhood. He indicated that her medications were Adderall and Xenical. He also indicated that she was status post drug rehabilitation for unrelated medications. Respondent diagnosed ADHD by history and exogenous obesity. He prescribed Adderall and Xenical. She was referred for tummy tuck surgery. Her next visit was on October 14, 2006, with a finding of fluid accumulation in the abdomen and pain. Impression was seroma, status post paniculectomy, and the site was aspirated.

67. The CURES Patient Activity Report (PAR) for J.B. for January through October 2006 indicated that in January 2006, respondent prescribed amphetamine salt combo (Adderall) 10 mg #25. In March 2006, the dose was 20 mg and the number increased to 120. In May 2006, Adderall XR 20 mg was initiated. There is no documentation in JB.'s chart for the change in formulation. In September 2006, respondent prescribed Actiq, a rapid-acting form of fentanyl, to J.B., as well as Ambien. In October 2006, respondent prescribed APAP

oxycodone to J.B. There is no documentation in J.B.'s medical records indicating that these controlled substances were prescribed, or any medical indication for the prescriptions.

2007

68. J.B. consulted respondent only once in 2007, according to respondent's medical records for her. On August 10, 2007, the records indicate a wellness check. It is indicated that she is on Adderall 20 mg daily for three months.

69. The CURES PAR for J.B. for February through December 2007, indicates that in February 2007, respondent prescribed amphetamine salt combo for J.B. There is no documentation in the patient's medical record for the reason for the change back to this formulation from the Adderall XR. In April 2007, respondent increased the number of tablets of amphetamine salts 30 mg to #100 (from #30), with no documentation of the reason for this increase. In August 2007, amphetamine salt combo 30 mg #90 was prescribed.

70. J.B.'s CURES PAR for February through December 2007, also indicates that respondent prescribed the following controlled substances for J.B. with no documentation in the record that they were prescribed or the rationale for prescribing them: APAP/Hydrocodone 500/5 in March 2007; temazepam (Restoril) 15 mg in March 2007; Lunesta 3 mg in April, May, October and December 2007; Oxycontine 40 mg #30 and Oxycontin 40 mg #20 on the same day in July 2007; and Zolpidem (Ambien) 10 mg in October 2007.

2008

71. J.B. consulted respondent in January 2008, with complaints of acute abdominal pain and vomiting. Respondent diagnosed acute cholecystitis based on the patient's mother's medical history and physical examination. Respondent prescribed Toradol and a reduced fat diet. In J.B.'s records in May 2008, there is a laboratory report on drugs of abuse from Marin General Hospital indicating a test positive for amphetamines. The test was related to J.B.'s arrest in May 2005 for DUI/hit and run.

72. The CURES PAR for J.B. for January through May 2008, indicates that respondent prescribed amphetamine salt combo in January, February, and May 2008, with no indication in the medical record of its continued prescription or the rationale for the medication. Respondent also prescribed Alprazolam (Xanax) in January and May 2008; Lunesta in January, February, and May 2008; Zolpidem in January 2008; APAP/oxycondone 325/10 in March 2008; and oxycodone in April 2008 with no documentation in the record.

73. J.B. was seen in respondent's office on June 1, 2008, with a chest wall contusion from a motor vehicle accident, presumably from the car crash into her neighbor's house on May 30, 2008, which resulted in her DUI/hit and run arrest. Respondent found left breast ecchymosis and a locally tender sternum, as well as a possible breast implant rupture. A chest x-ray was negative. Tylenol, Advil, and an ice pack were recommended. J.B. was

seen again on June 22, 2008. She completed a diabetic flow chart and complained of inability to sleep at night. She suffered from anxiety over her probable left breast implant rupture. Respondent noted referral to a psychiatrist for anxiety and a plastic surgeon for the breast implant rupture. On July 12, 2008, J.B. again saw respondent complaining of continuing breast pain from the accident. She has seen a plastic surgeon and immediate surgery could not be done. She remained anxious. Respondent prescribed alprazolam and Advil. She next consulted respondent on August 7, 2008, requesting help with a prior authorization for an MRI from her plastic surgeon. Respondent has in the record a report from the plastic surgeon dated September 10, 2008, on a bilateral breast MRI order by the plastic surgeon indication no breast implant rupture. Respondent saw J.B. after this report on September 12, 2008. Breast asymmetry from the accident was noted as well as the negative MRI. Respondent's impressions were mastitis and costochondritis. He prescribed alprazolam and Ambien.

74. Respondent had the Petaluma Police report on the October 23, 2008, traffic stop in his records. He also had the October 29, 2008, police report for driving on a suspended license and the November 7, 2008, incident report for the search warrant execution.

75. J.B.'s last visit with respondent in 2008, was on November 26, 2008. Respondent lists MVA (motor vehicle accident), asymmetry of breast implants, costochondritis, insomnia, migraine headaches, and anxiety from rupture of implants as indications for the visit. He prescribed Advil, Adderall, and Ambien.

76. The CURES PAR for J.B. for June through November 2008, indicated that respondent prescribed amphetamine salt combo in June, July, September, and October 2008, and mixed amphetamine salts in August and November 2008. He noted a prescription for Adderall in November 2008, in J.B.'s records, and no rationale was given for the continued prescription of amphetamines in light of the patient's arrests for methamphetamine possession and intoxication and her court-ordered drug treatment. Respondent prescribed Alpraxolam in June 2008, APAP/oxycodone in July and October 2008, Lunesta in July 2008, zolpidem in August, October, and November 2008, with little or no documentation. In September 2008, he prescribed sedative hypnotics Alpraxolam and zolpidm. Temazepam was prescribed in October 2008, as well as Oxycontin in October 2008, and APAP/hydrocodone bitartrate 325/10 in November 2008.

2009

77. J.B.'s first office visit in 2009 to respondent was on April 25, 2009. Respondent listed her present illness as ADHD and notes that she has been on Adderall since 2001. He also lists constochondritis post MVA, and migraine headaches. Respondent records prescriptions for Provigil 200 mg for ADHD. There were notations on the side margin of the chart with no explanation. They read: "5/29/09 – alprazolam 2 #30; [illegible] 5/500 A#30; 5/6/09 zolpidem #20; 5/3/09 – Adderall 20 #60; 5/20/09 phenter 37.5; 5/25/09 – alprazolam #45 ½ q12h; 4/29/09 [illegible]."

78. The CURES PAR for J.B. for January through April 2009, indicates that respondent prescribed Provigil four times under the same prescription number and she filled the prescriptions on March 21, 2009 (2 tablets), April 2, 2009 (2 tablets), April 3, 2009 (1 tablet), and April 4, 2009 (5 tablets), all well before the April 25, 2009, office visit. In that time period, respondent prescribed alprazolam in January 2009, zolpidem in January and March 2009, mixed amphetamine salts in January 2009, and Lunesta in January 2009, all without documentation in the record that they were prescribed or the purpose for which they were prescribed.

79. J.B.'s next office visit to respondent in 2009 was on May 31, 2009. She complained of an inability to focus, disorganization, and faulty memory. Respondent's diagnosis was that she needed Adderall. He diagnosed ADHD, costochondris, and migraine headaches. He prescribed Adderall. In the lower right hand corner of the form, respondent noted "5/28/09 – alprazolam #30." In her chart was a Novato Police report detailing an incident in June 2009, where she was cited for operating a motor vehicle without a court ordered ignition interlocking device.

80. J.B. next saw respondent in his office on October 30, 2009. Respondent made the same diagnoses and prescribed Adderall, Tylenol/Advil, and Imitrex. The last office visit in 2009, was on December 20, 2009, where J.B.'s present illness was listed as "sober months." Respondent's diagnoses were chronic costchondritis, ADHD, and vascular headache. J.B.'s chart indicated a recommendation for Adderall.

81. The CURES PAR for J.B. for May through December 2009, indicates that respondent prescribed for J.B. phentermine HCl 37.5 mg #20, APAP/hydrocodone 500/5 #30, and alprazolam in May 2009; amphetamine salt combo and alprazolam in August 2009; amphetamine salt combo in September 2009; mixed amphetamine salts in November 2009; and amphetamine salt combo in December 2009. Although respondent's margin notes and other notes indicate a few of these prescriptions, four of which are accounted for, the remainder are not accounted for in the record and the drugs named in the chart have no rationale for the prescriptions documented.

2010

82. Records available indicated that J.B. had an office visit with respondent on January 8, 2010, for acute recent vaginal bleeding. Respondent's plan was to order a pelvic sonogram, prescribe Premarin, and refer to a specialist. The CURES PAR for J.B. for 2010 indicates that respondent prescribed amphetamine salt combo in January 2010. There is no notation in the chart of this prescription.

83. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted gross negligence, repeated acts of negligence, and incompetence in that he prescribed controlled substances for a person with whom he had an intimate relationship predating any prescription, whom he married in 2007,

with full knowledge of the fact that she had abused and was addicted to amphetamines. He failed to refer her to another physician for management of medical conditions which he felt entailed the necessity for treatment with controlled substances. Further, he prescribed amphetamines with the full knowledge that the patient had abused and was addicted to methamphetamine. He continued to prescribe amphetamines even though more than once during respondent's treatment, she was arrested, convicted, and ordered into drug rehabilitation for methamphetamine possession, possession for sale, and being under the influence of methamphetamine.

84. Respondent prescribed amphetamines to J.B. for ADHD without examination and diagnosis. Respondent did no work up to determine if J.B. suffered from adult ADHD or refer her out to a specialist for testing and diagnosis. He did not entertain differential diagnoses, such as addiction or antisocial personality disorder, before assuming adult ADHD and prescribing amphetamines. To the extent respondent likened ADHD to diabetes or thyroid disease in that just as lifelong insulin is required for diabetics and thyroid hormone for thyroid disease, respondent exhibits a lack of knowledge concerning childhood ADHD. Childhood ADHD does not always result in adult ADHD and adult ADHD is treated differently. Lifetime amphetamines are not required to treat adult ADHD, especially in a patient addicted to methamphetamine. Respondent failed to consider alternatives to amphetamines to treat J.B. such a tricylic antidepressants or bupropion, for a patient he knew had abused and was addicted to methamphetamine.

85. To the extent respondent may have been treating J.B. for her addiction by prescribing stimulant controlled substances, there is no such drug treatment protocol for methamphetamine addiction, and there is no documentation in J.B.'s records that this was the case. Further, when J.B. was arrested for methamphetamine use despite respondent's prescriptions, this would indicate that any such addiction treatment protocol was ineffective. Respondent continued prescribing amphetamines.

86. Respondent increased the number of Adderall pills prescribed to J.B. within a certain time period without any rationale or documentation in the record for the change.

87. Respondent prescribed narcotic controlled substances to J.B. other than amphetamines with no rationale for their use of any consistent documentation in the record of the prescriptions. In 2006 and 2007, respondent prescribed Actiq, oxycodone and oxycontin with no record of an examination, diagnosis, or medical indication noted, or any rationale for the high doses prescribed.

88. Respondent prescribed hypnotic controlled substances for J.B. with no documentation of the prescriptions or any examination to confirm a medical indication for the prescriptions. Respondent prescribed temazepam in March 2003; Lunesta in April and May 2007, with no documentation of the prescriptions, diagnosis, or medical indication in the record.

89. Respondent diagnosed "costochondritis" in J.B. four months after her motor vehicle accident in May 2008, when he found a locally tender sternum, and continued with this diagnosis through October 2009. Costochondritis is a benign, usually self-limiting, condition which is treated with non-steroidal anti-inflammatory agents and only rarely treated with narcotic pain killers or muscle relaxants. There is no indication that respondent performed any examination to confirm this diagnosis or considered any differential diagnosis. To the extent that respondent attributes his prescription for narcotics and hypnotics to this condition; he failed to document any examination or testing to confirm costochondritis or any rationale for the prescription of narcotic pain killers or hypnotics.

90. Respondent does not document any discussions with J.B. concerning treatment with amphetamines, narcotic analgesics, or hypnotics prior to prescribing, no written contract detailing expectations, no informed consent, and no follow up notes indicating functional improvement or lack of aberrant behavior as signs of progress in treatment.

Prescribing without Examination/Medical Indication – Patient J.B.

91. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted prescribing without examination and medical indication in violation of the law. Respondent prescribed dangerous drugs and controlled substances to J.B. without appropriate examination and medical indication. He prescribed amphetamines for J.B. without examination or testing to confirm or rule out adult ADHD, without consideration of medications other than those to which she was addicted and without documentation of any progress on the medication. He continued to prescribe amphetamines after it was obvious that she was addicted and sought to obtain more by illegal means.

92. Respondent prescribed narcotic analgesics without examination or testing to determine an accurate diagnosis or medical indication. The dosages of the narcotics prescribed were large and could have been dangerous. In some cases, narcotic analgesics were prescribed with no indication in the record at all for the prescription of any notation of the prescription.

93. Respondent prescribed hypnotics for J.B. without examination or testing to determine an accurate diagnosis or medical indication.

Inaccurate/Inadequate Records – Patient J.B.

94. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted unprofessional conduct in that respondent kept inaccurate and inadequate medical records for J.B. in that they were illegible, inaccurate and sketchy. He failed to record all prescriptions for narcotic and hypnotic controlled substances and failed to document a full history, particularly an addiction history, physical examination, differential diagnosis, diagnosis or rationale for the prescribing of the controlled substances. He failed to document any treatment plan.

95. Respondent did not document any release or communication with any of J.B.'s prior health care providers or concurrent treatment providers. Respondent failed to document follow up finding on J.B.'s prescriptions, particularly for amphetamines, to warrant continuation of the drugs.

Gross Negligence/Negligence/ Incompetence – Patient M.F.

96. On May 8, 2007, respondent undertook to care for and treat Patient M.F., a 22-year-old male. M.F. filled out a patient history form. Under medical history, he listed groin pain and headaches; he listed his current medications as Oxycontin, Vicodin, and multivitamins. He listed lower back pain as a current complaint. Under substance abuse, he listed alcohol and marijuana, past and current use. M.F. also filled out a pain comfort assessment guide wherein he described aching, shooting, stabbing, gnawing, penetrating, and miserable pain interfering with all aspects of his life, relieved only by Celebrex and pain medications. M.F. provided respondent a copy of a right groin sonogram dated 12/07/2005 indicating a palpable 7 x 4 cm right groin mass with clinical assessment of "abscess vs. lymphadenopathy, erythema, and swelling." M.F. also provided respondent a copy of a normal CT brain scan dated 05/10/2000. There is no indication of respondent's having obtained releases for information from M.F. to follow up on these findings or to obtain any other treatment records or consultations for his treatment of this patient.

97. Respondent filled out a pain assessment form with a diagnosis of lower back pain from a football injury in Nevada and weight gain. Pain location was listed as right anterior groin, right mid and lower back, and left anterior lateral head, and the present intensity was listed as 8/10. Under "What relieves the pain," respondent listed Celebrex 200 bid." Respondent listed the treatment as pain control. He also prepared a checklist for long-term opioid therapy in which he concluded that there was medical indication for use of Vicodin. He completed a patient physical examination form. To the side of the form, respondent listed Celebrex 200 daily and Norco q 6h. Records for May 8, 2007, include a copy of a prescription for trazodone #20, 1 qhs. Respondent did not have M.F. sign a pain treatment contract or order a drug screen. At no time during his treatment of M.F. for intractable pain did respondent order a CURES report or a drug screen.

98. The CURES PAR for M.F. indicates that on May 8, 2007, M.F. filled prescriptions from respondent for APAP/hydrocodone 325/10 #60 (generic for Norco) and APAP/oxycodone 325/10 #20 on May 8, 2007. The CURES report for M.F. also indicated that another physician had prescribed APAP/hydrocodone three times in March 2007, twice in April 2007, and once on May 7, 2007, the day before M.F. first consulted respondent. Respondent did not seek releases or obtain records and information from M.F.'s previous and concurrent medical providers before prescribing narcotic pain medication for M.F.

99. On May 13, 2007, M.F. was arrested by the Petaluma Police Department for driving under the influence of alcohol, and on August 24, 2007, he was convicted and placed on 36 months probation. It was not established by clear and convincing evidence that

respondent knew about this conviction. However, M.F. indicated in his patient history form that he abused alcohol and marijuana. There is no record that respondent provided informed consent to M.F. concerning the risks of large amounts of acetaminophen-containing controlled substances in combination with alcohol affecting liver function.

100. M.F.'s next appointment was on May 21, 2007, where vital signs were taken and quality of pain was noted. Respondent notes "Norco 10/325 #120 1 q5/7h, gabapentin 100 2 qhs, HSL BID, Advil 600 mg, bidx5, RTC 4 weeks." The CURES PAR for M.F. indicates that M.F. filled respondent's prescription for APAP/hydrocodone and clonazepam 0.5 mg #30 on May 21, 2007. Also, the report indicates that respondent issued an APAP/hydrocodone 325/10 #20 prescription, which M.F. filled on May 25, 2007. Respondent did not check the CURES PAR and has no record of the clonazepam prescription or its medical indication and no notation of the prescriptions filled on May 17, 2007 in M.F.'s medical record.

101. M.F.'s next appointment was on May 30, 2007. Respondent entered a complaint of anxiety and inability to sleep due to recurrent intrusive thoughts. He entered an assessment of anxiety reaction and past medical history of headaches and "slip disc" for which an x-ray was needed. Respondent's plan indicated "Klonopin [clonazepam] . . . , psych eval if cont." The next appointment was on June 15, 2007. Respondent noted that an MRI was done with results pending but does not note who ordered the test or for what reason. He noted that M.F.'s lower lumbar vertebrae were tender with decreased range of motion. He noted that M.F. had chronic pain syndrome from his football injury and anxiety reaction since age 16 for which he received psychiatric care. He diagnosed muscle spasms and indicated a plan including Advil, Norco, gabapentin, Percocet and Klonopin. He indicated the need for a psychiatric evaluation. The CURES PAR for M.F. indicates that on June 15, 2007, M.F. filled prescriptions from respondent for PAP/hydrocodone, APAP/oxycodone, and clonazepam. M.F. also filled a further prescription from respondent for clonazepam on July 7, 2007, and this prescription is nowhere noted in respondent's records for M.F. The report also indicates that M.F. filled another physician's prescriptions for APAP/hydrocodone on June 13, 2007 and June 27, 2007.

102. M.F.'s next appointment was on July 19, 2007. Respondent noted complaints of radiating pain, headaches, anxiety and that his lower back was locally tender. Respondent's plan included discontinuing gabapentin and Percocet and prescribing Oxycontin, Norco, and Soma. The CURES PAR for M.F. indicates that on August 6, 2007, M.F. filled respondent's prescriptions and on August 10, 2007, M.F. filled resondent's prescription for another #120 APAP/hydrocodone 10/325. Respondent did not note indications for changing to Oxycontin in his notes and did not note the reasons for discontinuing Percocet and gabapentin.

103. M.F.'s next appointment was on August 20, 2007. Respondent completed a physical examination form indicating that M.F.'s present illness was headaches, with a past history of groin pain secondary to a football injury. He notes that M.F.'s pain is now 7/10. Respondent notes "Oxycontin 20 q7h, Norco 10/325, Gaba 100 q6h, Advil 4 tabs 5/7

[illegible]." Dosage and number of tablets is not mentioned except for Advil. At the bottom of the page for this appointment respondent notes "10/30/07 Norco 10/325 [illegible]." The CURES PAR for M.F. indicates that on August 20, 2007, M.F. filled two prescriptions issued by respondent for APAP/hydrocodone 325/10 #120 and one for Oxycontin 20 mg #60.

104. Respondent did not see M.F. in his office for more than a year. The next appointment was on September 10, 2008. The CURES PAR for M.F. indicates that between August 20, 2007 and September 10, 2008, M.F. filled prescriptions from respondent for clonazepam in August, November 2007, and January 2008; APAP/hydrocodone in September, three in October and November 2007. The PAR also indicates that another physician prescribed lorazepam and Subutex for M.F. and these were filled by M.F. in March 2008, indicating M.F. was being treated for addiction. None of respondent's interim prescriptions is recorded in respondent's chart for M.F., except for the APAP/hydrocodone on October 30, 2007, which was noted on the bottom of the August 20, 2007 progress note. At respondent's physician conference with the Board enforcement staff on February 17. 2011, respondent indicated that he has postdated prescriptions for scheduled medications.

105. At the September 10, 2008, visit, respondent filled out a physical examination form indicating a herniated disc, headache, and a pain level of 7/10. Respondent did not record any intervening medical history since his last appointment. He did not record any information about other physicians M.F. may have been consulting or what controlled substances he was receiving from other physicians. He did not request medical records from other physicians. Respondent did not order a drug screen or a CURES report. The CURES PAR for M.F. indicates that he filled respondent's prescriptions for Oxycontin and APAP/oxycondone (Percocet) on September 10, 2008. The Oxycontin was double the previous dose prescribed and while that are copies of respondent's prescriptions in the records, respondent did not document a rationale for the doubling of the Oxycontin dose. M.F.'s PAR also indicates that on September 11, 2008, he filled respondent's prescription for hydrocodone, a prescription not noted by respondent in M.F.'s record.

106. M.F.'s next appointment with respondent was on September 25, 2008. Respondent recorded a physical examination, listing the present illness as lower back pain from a football injury with a past history of allergy to gabapentin, causing headaches. Respondent notes vital signs and pain level, a stiff neck and decreased range of motion. He notes in the right margin, Oxycontin 40 mg #90, Percocet 10/325 #120, loose (sic) 20#, a 1000 calorie per day diet and the MRI of the lower spine. The CURES PAR for M.F. indicates that M.F. filled respondent's prescription for Ocycontin and APAP/oxycodone on September 25, 2008, but respondent did not document a reason for prescribing double the number of Oxycontin pills and almost three times the number of Percocet pills.

107. M.F.'s next appointment with respondent was on November 4, 2008. Respondent recorded a physical examination. He noted present illness as the same as the September 25, 2008 visit. He again noted the MRI showing a bulging disc in the lower back. He notes in the right margin, Oxycontin 40 mg #90 q8h Percocet 10/325 #120 q8h, and alprazolam 2 mg #20 q 18-24h in the record. There is no rationale for the alprazolam

prescription documented. The CURES PAR for M.F. indicates that on November 4, 2008, M.F. filled respondent's prescriptions for alprazolam, Oxycontin, and Percocet. The PAR also indicates that on December 1, 2008, M.F. filled respondent's prescriptions for alprazolam, oxycodone, and oxycontin. The prescription for alprazolam was not noted in the record. No reasons for the decrease in dosage of the oxycodone and number of pills for both Oxycontin and oxycodone were documented. In M.F.'s medical record, respondent has a copy of a prescription written to M.F. dated December 16, 2008, for Oxycontin and Percocet and the CURES PAR for M.F. indicates that on December 17, 2008, M.F. filled respondent's prescriptions for oxycondone and Oxycontin. There is no explanation for this prescription in M.F.'s medical record.

108. M.F.'s next appointment was on January 26, 2009. Respondent recorded a physical examination. Pain is noted as 5.5/10. Vital signs are recorded. Impression is lumbar discitis, bulging disc. Respondent noted prescriptions for Oxycontin, Percocet, and tramadol. The CURES PAR for M.F. indicates that on January 29, 2009, M.F. filled prescriptions for Oxycontin 40 mg #60 and #15. There is no explanation for the discrepancy in the number of pills or the fact that the prescriptions for Percocet and tramadol were apparently not filled.

109. M.F.'s final appointment was on March 9, 2009. Respondent recorded the same physical examination. The pain level was the same as the last visit. Respondent indicates that the lower back is tender and indicates a para spinal muscle spasm. Oxycontin, Percocet and alprazolam are prescribed. The CURES PAR for M.F. indicated that he filled the prescriptions on March 9, 2009.

110. Respondent's records for M.F. indicate that on March 10, 2009, respondent was contacted by a pharmacy to inquire concerning two refills on a prescription for Norco apparently written by respondent to M.F.'s brother. This was included in a prescription which also included Oxycontin and alprazolam. On that same date, M.F. presented a prescription written by respondent to M.F. for Oxycontin and alprazolam. Respondent verified that the prescriptions were falsified, and M.F. and his brother were arrested.

111. Respondent's conduct constitutes unprofessional conduct in that it was established by clear and convincing evidence through the testimony of a qualified expert that respondent's care of M.F. was an extreme departure from the standard of practice in that he did not discuss with M.F. the dangers of acetaminophen toxicity and continued to prescribe large doses of acetaminophen-containing controlled substances to M.F., for many months in a patient who admitted to continuous alcohol use. Before prescribing opioids on a long-term basis and in high doses, respondent failed to perform a medically adequate physical examination or determine positive medical indication to do so. There is not an adequate back pain history. He prescribed opioid pain medications on the strength of a few statements from the patient without corroborating the patient's claims, without laboratory tests, or radiologic work up. There was no substance abuse history taken even though the patient admitted to alcohol and marijuana use.

112. Even though it was obvious that M.F. had been or was being treated for his pain by other practitioners, respondent failed to obtain releases to consult with or to obtain records from other practitioners before continuing to prescribe pain medications.

113. Respondent failed to do a proper lower back pain evaluation and/or refer M.F. to a specialist in the treatment of back pain or pain management. Respondent failed to formulate a treatment plan or goals for M.F. In a patient with a history of continuous marijuana and alcohol use, respondent failed to order a drug screen or check CURES for evidence of parallel prescribing or previous prescribing.

114. Respondent failed to take an interim history when he resumed M.F.'s care in September 2008, after more than a year. He failed to inquire as to pain experienced, drugs taken, other practitioners consulted, or any drug or alcohol abuse or arrests. Respondent simply resumed prescribing opioid controlled substances. Respondent continued to prescribe controlled substances in the period between August 20, 2007, and September 10, 2008, when M.F. had no office visits with respondent. Respondent failed to carefully monitor the use of opioid pain medication in a patient who demonstrated the potential for abuse. Respondent failed to document in any office note any functional benefit or loss from the use of controlled substances for pain that warranted any continued use, modification, change, or discontinuance of these medications.

Prescribing without Examination/Medical Indication – Patient M.F.

115. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted prescribing without examination and medical indication in violation of the law. Respondent prescribed opioid pain medications to M.F. without a thorough physical examination confirming the fact, nature, and etiology of the pain, without confirming laboratory or radiologic testing, without obtaining records of previous or concurrent physicians, and without taking a drug/alcohol abuse history. Respondent continued to prescribe opioid pain medications to M.F. during a period of more than one year in which he had no office appointments with M.F. Respondent had no treatment plan for M.F. and did not indicate any benefit or detriment from the controlled substances which had been prescribed in M.F.'s patient record. Respondent failed to indicate in M.F.'s patient record any rationale for the amount and kind of controlled substances prescribed or any medical reason for an alteration in dosage, amount, or kind of medication.

Inaccurate/Inadequate Records – Patient M.F.

116. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted unprofessional conduct in that respondent's records for M.F. were inaccurate and inadequate medical records in that he failed to record or keep a copy of all of his controlled substance prescriptions for M.F. and failed to document a confirmatory physical examination, diagnosis, treatment plan or rationale of continued prescription of pain medications. Respondent consistently prescribed opioid pain medications without documentation of any confirmatory physical examination,

laboratory tests, x-rays, consultations, or referral. Respondent did not document any treatment plan for M.F. or follow up examinations indicating the result of any treatment or prescription in alleviating pain or improving quality of life.

Gross Negligence/Negligence/Incompetence – Patient A.B.

117. Respondent was retained to treat A.B. by her parents when she was a young child, but respondent had no office medical records for A.B. prior to May 2007. A.B. filled out a new patient registration form for respondent on June 29, 2007. She was then 28 years of age. In an office visit note for August 24, 2007, respondent noted that on July 12, 2007, A.B. was in a motor vehicle accident and that she was locally tender on the right side of her neck. A pain diagram indicates pain from 3-8/10 and reduced ability to participate in physical activities. A pain assessment form is filled out concluding that A.B. is in intractable pain. Diagnosis is indicated as posterior neck pain and headache. Plan of treatment indicates local heat, stretching, NSAID prn, and NAC as needed 30-90 per day.

118. A.B.'s records contain an undated checklist for long term opioid therapy with an indication, but no detailed data, or a complete history and physical examination. This form indicated that there was medical indication for use of a controlled substance and that A.B. was warned of the risks and benefits of such therapy. CURES records indicate that A.B. filled respondent's prescriptions for alprazolam on February 7, 2008, February 15, 2008, and March 10, 2008 and for hydrocodone 500/5 #100 on February 7, #60 on February 15, # 100 on March 10, and #60 on March 27, 2008.

119. A.B.'s next visit was on March 31, 2008. Cervical pain and pain in the right shoulder and scalp were noted, along with right temporal headache. Respondent notes Vicodin, Naprosyn, alprazolam, local heat, counter irritant, and rehab massage. There is a notation for x-ray in six weeks. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone on March 31, April 15, and April 30, 2008; hydrocodone on May 20, 2008, and alprazolam on March 31, April 21, April 30, and May 19, 2008.

120. A.B.'s next visit was on June 4, 2008. Neck pain was noted as well as an ER visit on May 29, 2008, with no details other than "no x-ray," "MRI scheduled" in Greenbrae, and "missed 4 days work." Vital signs were recorded. Range of motion is noted to be decreased in the neck and shoulder, with the right side of neck tender. Respondent notes Norco, and alprazolam, as well as Advil as treatments. There is a report on an MRI taken on June 6, 2008, which had been ordered by H.K., M.D., which indicates a diagnosis of thoracic outlet syndrome with scalene entrapment. CURES records indicate that A.B. filled respondent's prescription for alprazolam on June 13, 2008.

121. A.B.'s next office visit was on June 29, 2008. A physical examination form was completed and present illness was noted as motor vehicle accident. Respondent notes recent neck pain and right shoulder pain radiating down to the right hand. He notes depression secondary to chronic pain. Respondent notes TENS, biofeedback, alprazolam, gabapentin, and Norco as treatments. Vital signs included a heart rate of 100 bpm.

Respondent indicates cervical discitis and chronic pain syndrome. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone, and alprazolam on June 29, July 24, July 28, August 22, August 24, and August 26, 2008, filled at various pharmacies.

122. On August 29, 2008, respondent received a fax transmittal from H.K., M.D. Dr. K. alerted respondent that she had ordered a CURES Patient Prescription History for A.B. for May 1, 2008 through August 25, 2008, and that the report, which was included with the fax, indicated that A.B. was receiving prescriptions for hydrocodone from several different providers, with respondent being the most frequent provider, and filling the prescriptions at different pharmacies. There is no record that respondent addressed with A.B. the issue of receiving narcotic prescriptions form multiple providers and filling them at multiple pharmacies.

123. A.B. next saw respondent on September 2, 2008. A physical examination form was completed. Respondent notes the present complaint is neck pain right side, with past history of motor vehicle accidents, one in November 2004, and another in November 2007. No mention is made of the July 2007 accident which initiated respondent's pain treatment for A.B. It is noted that the neck is locally tender. Pain level is recorded. Impression is acute cervical discitis and pain cervical spine. Respondent notes Norco and Advil. No discussion of Dr. K's suspected drug abuse was noted; no drug abuse history was taken; and no CURES report was ordered. No warning concerning maximum daily intake of acetaminophen was noted. CURES records indicate that A.B. filled respondent's prescription for hydrocodone on September 4, 2008.

124. A.B. next saw respondent on September 11, 2008, for periodic neck pain and numbness. Respondent noted the need for an MRI of the cervical spine. Pain was noted. Heart rate was noted. Respondent again noted cervical discitis and neck pain. He noted trazodone, gabapentin, Norco, and alprazolam. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone on September 11, September 23 and September 24, 2008 and for alprazolam on September 18, and September 27, 2008.

125. A.B. next saw respondent on October 9, 2008. A physical examination form was completed. Respondent mentioned three motor vehicle accidents. He noted the results of an MRI scan done June 6, 2008. Pain was noted and heart rate was noted. Respondent notes Norco, alprazolam, and gabapentin. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone on October 9, October 20, and November 1, 2008. She filled respondent's prescription for alprazolam on October 11, 2008.

126. On October 25, 2008, respondent received a profile on A.B. from Longs Drugs in Santa Rosa, where the pharmacist indicates that A.B. received 420 hydrocodone tablets in August 2008, 360 hydrocodone tablets in September 2008, and 275 hydrocodone tablets in October 2008. A.B. had submitted a request for refill of the previous prescription. Respondent rejected the request for refill but continued to prescribe hydrocodone in large amounts to A.B.

127. A.B. next saw respondent on November 16, 2008. In addition to the usual notes respondent wrote for this patient, he noted a new motor vehicle accident in October 2008, indicating it was caused by a drunk driver. He noted a tender upper neck and rapid heart rate, with impression being sinus ventricular tachycardia secondary to anxiety, white coat syndrome and, right cervical spine radiculopathy. Respondent noted Advil, Toprol XL for palpitations, alprazolam, Norco, gabapentin and Soma. Respondent did not obtain an EKG or examine A.B. for causes of her tachycardia, including tests for anemia, thyroid problems, or stimulant abuse. Respondent did not refer A.B. to a cardiologist for assessment of her tachycardia. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone and alprazolam on December 1, 2008.

128. On December 8, 2008, respondent received a profile on A.B. from the pharmacist again. It indicated A.B. had requested a refill of respondent's prescription for hydrocodone, which she filled on December 1, 2008. Respondent rejected the request, but authorized a refill for December 24, 2008.

129. A.B. next saw respondent on December 11, 2008. Present illness was not listed. There is a note to have A.B. see a psychologist. Heart rate was slightly elevated. Respondent prescribed alprazolam. She filled the prescription on December 24, 2008.

130. A.B. next saw respondent on January 20, 2009. Respondent noted that A.B. was seeing a psychologist three times a week. Her heart rate was elevated. Impression included supraventricular tachycardia caused by anxiety and cervical spine neuropathy. Respondent lists medications as Toprol, Norco, gabapentin, Flexeril, and alprazolam. Pharmacy records show A.B. filled respondent's prescriptions for hydrocodone on February 2, and February 28, 2009 and alprazolam on February 2, and March 3, 2009 and tramadol on February 2, 2009.

131. A.B. saw respondent again on April 6, 2009. At this visit, respondent had A.B. sign a Long Term Controlled Substances for Chronic Pain Sample Agreement, and in it, A.B. agrees to receive controlled substances only from respondent, to fill those prescriptions only at one pharmacy, to inform respondent on any new medications, access to all other physicians she has consulted, to submit to unannounced urine or serum drug screens, to know that lost, stolen or damage medications will not be replaced, to know that early refills will not be given, and to understand that failure to comply with the agreement will result in ceasing the prescribing of controlled substances for A.B. She also signed a Consent for Chronic Opioid Therapy. Impression includes odontoid process malposition, headaches, chronic pain, and depression. Notations indicate massage, local heat, Norco, tramadol, and "smoke ½ ppd."

132. CURES records indicate that A.B. filled no prescriptions for controlled substances between February 2, and June 6, 2009. At CVS Pharmacy A.B. filled respondent's prescriptions for varying numbers of tablets of hydrocodone June 6, July 6, July 21, August 3, August 10, September 10, September 29, December 21, 2009. At a different CVS Pharmacy A.B. filled respondent's prescriptions for varying numbers of tablets of

hydrocodone on June 8, June 17, June 18, June 22, July 8, July 26, August 9, August 16, August 28, September 8, September 11, October 8, November 8, November 30, December 5, and December 10, 2009. The number of hydrocodone pills documented would indicate that A.B. ingested an average of 11 grams of acetaminophen and 350 mg of hydrocodone per day between June 6, 2009, and the end of December 2009. Respondent's chart for A.B. indicates a large number of refill requests for hydrocodone, some of which were refused, but most were approved with the refill amount sometimes limited. These requests came from two CVS pharmacies and occasionally Walgreen's.

133. A.B. filled respondent's prescriptions for varying number of tablets of alprazolam on June 8, June 17, July 8, August 9, August 28, September 8, September 11, October 8, November 8, November 30, and December 10, 2009, from one pharmacy.

134. In respondent's chart there is a communication dated June 29, 2009 from the pharmacy indicating to respondent that his patient was filling prescriptions at two locations. This communication was after A.B. signed the agreement for chronic pain. Respondent for the first time ordered a CURES PAR report. Respondent did not take any other action.

135. In respondent's chart for A.B. is a letter from her dated August 19, 2009. She reminds respondent that she is a long time patient and that she is suffering from anxiety, depression, and neck pain radiating to her right hand. She indicated she has developed a fear of leaving her home and wants to try antidepressants. There is another letter dated September 29, 2009, wherein she asks for help obtaining disability benefits and indicates that onset of her disability as November 25, 2008, and that it includes anxiety, depression, and neck pain. She requested disability benefits through at least December 25, 2009. There is no indication that respondent acted on these requests.

136. A.B.'s next appointment with respondent was on January 11, 2010, nine months after the previous appointment. A patient physical examination form was completed. Present illness listed as motor vehicle accident with malalignment at C1-C2 and HNP C6-7. There is an indication of Toprol XL and an illegible entry apparently concerning pain medication. Present history is listed as radiating neck pain right side and depression. Heart rate is listed as 116 bpm. Neck is described as locally tender with decreased range of motion. Impression is acute cervical pain; C1-C2 malalignment; HNP C6-C7; chronic pain. CURES records indicate that A.B. filled respondent's prescriptions for hydrocodone on January 11, January 21, February 2, February 25, March 2, and March 16, 2010. She filled his prescriptions for alprazolam on January 11, January 27, February 12, and March 12, 2010.

137. Her next appointment was on March 24, 2010. The situation had not changed much. Respondent prescribed Advil, Norco, Soma, alprazolam, and Cymbalta. The name of A.B.'s psychologist is mentioned. CURES records indicate she filled prescriptions for hydrocodone on March 24, April 1, April 3, April 8, and April 20, 2010. At this appointment respondent ordered a urine drug screen for the first time for alprazolam, Norco, Soma, and tramadol. The specimen was collected on March 24, 2010, and results were

reported on April 5, 2010. Although respondent had consistently prescribed alprazolam, the drug screen was negative. There is no indication in the record that respondent addressed this inconsistency with A.B. Respondent continued to prescribe alprazolam.

138. A.B.'s next appointment was June 23, 2010. The situation had not changed. No mention is made of the urine test results. Advil, Norco, Soma and alprazolam were prescribed. Respondent's records indicate prescriptions for hydrocodone were filled on May1, May 2, May 30, May 31, June 23, July 23, August 23, August 25, September 26, September 27, and October 12, 2010. For alprazolam, respondent's records indicate prescriptions filled for May 3, May 20, June 23, June 23, July 19, August 19 and September 27, 2010.

139. A.B.'s last visit was November 7, 2010. In addition to the usual documentation, A.B.'s present illness included bronchitis. Medications were listed as Keflex, Norco, and alprazolam. A diagnosis of acute bronchitis was made. Respondent's records indicate prescriptions for hydrocodone were filled on November 22, December 6, 2010, January 7, January 18, and February 7, 2011. For alprazolam, respondent's records indicate a prescription filled on December 15, 2010 and January 14, 2011.

140. On December 2, 2010, respondent obtained a CURES PAR for A.B. from June 2, 2010 through December 2, 2010, which indicated that A.B. had filled his prescriptions. Respondent's only comment on the sheets was "not multiple MD's." Dr. H.K.'s message to respondent indicating that A.B. was receiving prescriptions for controlled substances from multiple providers was received in August 2008.

141. It was established by clear and convincing evidence through qualified expert witnesses that respondent's conduct constitutes gross negligence and incompetence in his care and treatment of Patient A.B. in that he had provided care for A.B. for injuries sustained in at least three separate motor vehicle accidents for over four years, respondent did not document a complete work up or physical examination. There is no detailed psychological assessment, no detailed orthopedic or neurological history and physical. He did not take a substance abuse history, a history of prior pain treatment, or do an assessment, including diagnostic tests. He did not document a recognized medical indication for long term use of controlled substances. Respondent failed to refer her to a pain management physician and/or spine specialist for the definitive treatment of her cervical pan and radicular complaints. He demonstrated a lack of knowledge of appropriate treatment options for spinal pathology.

142. Respondent did not consider medication misuse or diversion or refer her to an addiction/pain management specialist for assessment. Respondent did not develop a treatment plan for A.B. or set forth clear objectives for treatment by which the treatment plan could be evaluated.

143. Respondent failed to obtain a release of information authorization for A.B. for her previous or contemporaneous treating physicians, contact her previous physicians, or search the CURES program for information until very late in his care. When he was notified

of possible drug abuse by another treating physician or informed by pharmacies of problems with her prescriptions, respondent failed to respond and failed to discuss this information with the patient or alter his treatment or prescribing accordingly.

144. Respondent failed to consider non-narcotic treatments for the patient's cervical pain such as physical therapy, biofeedback, or injection therapy before prescribing controlled substances. Opiates are not a first line treatment for chronic intractable pain. Respondent failed to consider or warn A.B. of the dangers of long term use of acetaminophen.

145. Respondent failed to properly evaluate and treat A.B.'s tachycardia. He did not obtain an EKG or consider potential causes. He failed to refer A.B. to a cardiologist for definitive diagnosis and treatment.

146. In noting A.B.'s constant depression and anxiety which was at times debilitating, respondent did not consult with her psychologist. Even when A.B. asked to be placed on antidepressants respondent did not consider a psychiatric referral or at least a consultation.

147. Respondent did not have A.B. sign a contract for pain treatment until April 2009, years after he had begun treatment with controlled substances, and even after the agreement was signed, he took no steps to stop or curtail or alter his treatment when A.B. clearly violated the agreement.

Prescribing Without Examination/Medical Indication – Patient A.B.

148. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted prescribing without examination and medical indication in violation of the law. Respondent prescribed opioid pain medications to A.B. without a thorough physical examination confirming the fact, nature, and etiology of the pain, without confirming laboratory or radiologic testing, without obtaining records of previous or concurrent physicians, and without taking a drug/alcohol abuse history. Respondent continued to prescribe opioid pain medications and benzodiazepines to A.B. during long periods in which she had no office appointments with respondent. Respondent had no treatment plan for A.B. and did not indicate any benefit or detriment from the controlled substances which had been prescribed in A.B.'s patient record. Respondent failed to indicate in A.B.'s patient record any rationale for the amount and kind of controlled substances prescribed or any medical reason for an alteration in dosage, amount, or kind of medication.

Inaccurate/Inadequate Records – Patient A.B.

149. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct constituted unprofessional conduct in that respondent's records for A.B. were inaccurate and inadequate medical records in that he failed to adequately describe any lack of aberrant behavior, lack of side effects, or the

efficacy of the drug treatments which would warrant ongoing treatment or alterations in dosage or amount of medications prescribed. Respondent's records for A.B. are sketchy, disorganized, illegible and inaccurate. He failed to record all prescriptions for controlled substances and keep track of all refills authorized and not authorized. Respondent failed to document a detailed confirmatory physical examination supporting his diagnoses, failed to document a treatment plan, the efficacy of that treatment plan, or any rationale for the continued treatment of A.B.'s cervical pain with large amounts of narcotic pain medication containing acetaminophen.

Repeated Acts of Negligence – All Patients

150. It was established by clear and convincing evidence through the testimony of qualified experts that respondent's conduct in the care and treatment of patients H.A., M.B., M.H., J.B., M.F., and A.B. constituted repeated acts of negligence.

Expert Testimony

151. Three experts testified in this matter. Kimberly Duir, M.D. is a family medicine practitioner. She opined that respondent's erroneous diagnosis of patient H.A. of alcoholism was picked up by nurse practitioner and then passed to a psychiatrist. It was an extreme departure from the standard of practice for respondent to use such high doses of Librium in a person of H.A.'s age, especially without independently verifying the need for such medication. She further testified that respondent's care of M.B. was an extreme departure from the standard of practice. Respondent did not see that this patient was adequately cared for at the facility. She was especially concerned about respondent requesting M.B. to write a letter on his behalf.

John Dervin, M.D. is a family practitioner and has taken some pain management training. He testified about four patients. He found that respondent's care and treatment of M.H., J.B., M.F., and A.B. were all an extreme departure from the standard of practice. He commented on the high doses of controlled substances prescribed for these patients, with little or no documentation constitutes an extreme departure from the standard of practice and excessive prescribing. He opined that the failure to get CURES reports for the patients constituted a simple departure from the standard of practice.

Jacob Rosenberg, M.D. is a pain management specialist. He testified about four patients: M.H., J.B., M.F., and A.B. He found that respondent's overall care of M.H., J.B., M.F., and A.B., each were an extreme departure from the standard of practice. He also found, particularly for patient J.B., that respondent demonstrated a lack of knowledge in how to treat an addicted patient.

Aggravating Factors

152. On November 20 1991, an accusation was filed against respondent by the Board. It alleged violations of Business and Professions Code sections 2236 and 2237

(conviction of four counts of violating Health and Safety Code section 11153, subdivision (a), issuing prescriptions without a legitimate medical purpose); section 2242 (prescribing dangerous drugs without a good faith prior examination or medical indication); section 725 (excessive prescribing); and section 2234, subdivision (e) (unprofessional conduct – soliciting sexual favors from a patient).

153. On February 15, 1995, a Supplemental Accusation was filed. It alleged violations of Business and Professions Code sections 2234, subdivisions (b) and (c) (gross negligence/repeated negligence in that the diagnoses of five patients who were involved in minor vehicle accidents were not supported by medical records or x-rays, indication for physical therapy referral inadequate, referral to unlicensed physical therapist, and failure to check on progress in physical therapy); and sections 810 and 2234, subdivision (e) (insurance fraud); and section 725 (excessive prescribing of treatment). With respect to one patient, it alleged a violation of Business and Professions Code section 2234, subdivision (c) (inappropriately prescribing prescription lenses, hypertension medication, and weight reduction medication without appropriate examination/medical indication/adequate instructions); section 810 and 2234, subdivision (e) (insurance [Workers Compensation] fraud); section 2261 (making or signing a document related to medicine which was false.); and section 125 (conspiracy with patient to defraud Workers Compensation). With respect to eight patients at a convalescent home in Novato, it was alleged that there were violations of Business and Professions Code section 725 (excessively and unnecessarily prescribing numerous x-rays and other diagnostic tests). With respect to a corporation which provided x-rays to patients and healthcare facilities in which respondent was an owner and shareholder, it was alleged that he violated Business and Professions Code section 2234, subdivision (b) (gross negligence in causing or allowing the corporation to employ unlicensed persons as radiological technicians to take x-rays). And with respect to respondent's representation on his letterhead, business cards, and advertisements that he was Board Certified by the American Board of Family Practice, when his certification lapsed in 1981, and was not renewed, it alleged a violation of Business and Professions Code sections 2234 (general unprofessional conduct and 2261 (making a false representation).

154. In November 1995, respondent entered into a stipulation and that stipulation was adopted by the Board as its Decision effective February 23, 1996. Respondent's certificate was revoked, but the revocation was stayed for a period of five years upon terms and conditions including an ethics course, physician monitor, controlled substance prescribing restrictions, drug logs, and restitution to the insurance company paying for the treatments of the five patients injured in the November 1991 auto accident.

155. On April 12, 1999, an Accusation was filed by the Board. This accusation alleged violations of Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence), and (d) (incompetence) with respect to the care and treatment of seven elderly or older patients at Novato Community Hospital. On May 7, 2001, effective immediately, the Board adopted a stipulation between the parties as its Decision in that matter, which provided for an extension of respondent's probation to

December 31, 2001, with additional terms and conditions including an oral clinical examination, education course, and physician practice monitor.

156. On December 24, 2001, a Petition to Revoke Probation was filed against respondent and on June 6, 2002, an Amended Petition was filed. The Amended Petition alleged that respondent had failed to document numerous prescriptions for controlled substances for one patient in his drug log and failed to document recommendations for marijuana to another patient. On April 17, 2003, the Board adopted as its Decision in this case a Stipulated Decision and Disciplinary Order which extended respondent's probationary period until January 1, 2004, and imposed further terms and conditions including a prescribing practices course, a medical record keeping course, maintenance of a record of all controlled substances prescribed, dispensed or administered, and psychotherapy. The Decision was effective May 19, 2003.

Respondent's Evidence

157. Respondent essentially refused to participate in the hearing. He indicated that he had changed his record keeping practice and was converting to electronic record keeping. He hired a compliance Nurse. He has a "cash only" practice in Novato, California where 50% of his patients consult him for pain management. He now orders CURES reports on each patient. Respondent also stated that he believed individuals had committed "perjury" concerning the case of H.A., but did not give specifics. There was no additional evidence of mitigation, extenuation or rehabilitation.

Conclusion

158. Respondent is not safe to practice medicine in California.

LEGAL CONCLUSIONS

1. By reason of the matters set forth pertaining to patient H.A. in Factual Findings 4 through 17, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence). The facts set forth in these Factual Findings set forth above constitute an extreme departure from the standard of practice and establish that respondent did not have sufficient knowledge to treat this elderly patient. By reason of the matters set forth in Factual Findings 4 through 18, and 151, cause for disciplinary actions exists pursuant to Business and Professions Code sections 2242, subdivision (a) (prescribing without examination and medical indication) and 2234 (unprofessional conduct). By reason of the matters set forth in Findings 4 through 19, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2266 (record keeping) and 2234 (unprofessional conduct).

2. By reason of the matters set forth pertaining to patient M.B. in Factual Findings 20 through 37, and 151, cause for disciplinary action exists pursuant to Business and Professions Code sections 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence). The facts set forth in these Factual Findings set forth above constitute an extreme departure from the standard of practice and establish that respondent did not have sufficient knowledge to treat this patient. By reason of the matters set forth in Factual Findings 20 through 40, and 151, cause for disciplinary actions exists pursuant to Business and Professions Code sections 2242, subdivision (a) (prescribing without examination and medical indication) and 2234 (unprofessional conduct). By reason of the matters set forth in Findings 20 through 42, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2266 (record keeping) and 2234 (unprofessional conduct).

3. The reason of the matters set forth pertaining to M.H., in Factual Findings 43 Through 54, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence).

4. By reason of the matters set forth pertaining to patient J.B. in Factual Findings 55 through 90, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence). The facts set forth in these Factual Findings set forth above constitute an extreme departure from the standard of practice and establish that respondent did not have sufficient knowledge to treat this patient for addiction. By reason of the matters set forth in Factual Findings 52 through 93, and 151, cause for disciplinary actions exists pursuant to Business and Professions Code sections 2242, subdivision (a) (prescribing without examination and medical indication) and 2234 (unprofessional conduct). By reason of the matters set forth in Factual Findings 52 through 95, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2266 (record keeping) and 2234 (unprofessional conduct).

5. By reason of the matters set forth pertaining to M.F. in Factual Findings 96 through 114 and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence). The facts set forth in these Factual Findings set forth above constitute an extreme departure from the standard of practice and establish that respondent did not have sufficient knowledge to treat this patient for addiction. By reason of the matters set forth in Factual Findings 96 through 115, and 151, cause for disciplinary actions exists pursuant to Business and Professions Code sections 2242, subdivision (a) (prescribing without examination and medical indication) and 2234 (unprofessional conduct). By reason of the matters set forth in Findings 96 through 116, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2266 (record keeping) and 2234 (unprofessional conduct).

6. By reason of the matters set forth pertaining to A.B. in Factual Findings 117 through 147 and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivisions (b) (gross negligence), (c) (repeated acts of negligence) and (d) (incompetence). The facts set forth in these Factual Findings set forth above constitute an extreme departure from the standard of practice and establish that respondent did not have sufficient knowledge to treat this patient for addiction. By reason of the matters set forth in Factual Findings 117 through 148, and 151, cause for disciplinary action exists pursuant to Business and Professions Code sections 2242, subdivision (a) (prescribing without examination and medical indication) and 2234 (unprofessional conduct). By reason of the matters set forth in Findings 117 through 149, and 151, cause for disciplinary action exists pursuant to Business and Professions Code section 2266 (record keeping) and 2234 (unprofessional conduct).

7. By reason of the matters set forth in Factual Findings 150 and 151 pertaining to all patients (H.A., M.B., M.H., J.B., M.F., and A.B.) cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivision (c) (repeated acts of negligence). The facts set forth in the Factual Findings above, whether jointly or in combination, constitute repeated acts of negligence.

8. The matters in aggravation as set forth in Factual Findings 2 (prior disciplinary action) and 152 through 156 (prior disciplinary action) have been considered in making the Order in this matter.

9. The matters set forth in Factual Finding 157, have also been considered in making the following order. Respondent is not safe to practice medicine in California.

ORDER

Certificate No. G 20523 issued to respondent Ray Poon-Phang Seet, M.D., is hereby revoked pursuant to Legal Conclusions 1, 2, 3, 4, 5, 6, and 7, separately and jointly.

DATED: 7/16/13

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

EDMUND G. BROWN JR.
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
VIVIEN H. HARA
Deputy Attorney General
State Bar No. 84589
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5513
Facsimile: (415) 703-5480
E-mail: vivien.hara@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **RAY POON-PHANG SEET, M.D.** 1116 "B" Street Petaluma, CA 94952 Physician and Surgeon's Certificate No. G 20523 Respondent.	Case No. 12 2008 190960 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about June 9, 1971, the Medical Board of California issued Physician and Surgeon's Certificate No. G 20523 to Ray Poon-Phang Seet, M.D. (Respondent). Unless renewed, the certificate will expire on November 30, 2013.

3. Prior disciplinary action was taken against this certificate as follows: On November 20, 1991, an Accusation was filed against Respondent, and on February 15, 1995, a Supplemental Accusation was filed. On February 23, 1996, a Decision became effective which read: Revoked,

Stayed, Five Years Probation with Terms and Conditions. On April 12, 1999, another Accusation was filed and on May 7, 2001, a Decision became effective, which read: Revoked, Stayed, Ordered to Continue Probation until December 31, 2001. On December 24, 2001, a Petition to Revoke Probation was filed, and on June 6, 2002, an Amended Petition to Revoke Probation was filed. On May 19, 2003, a Decision became effective, which read: Revoked, Stayed, Two Years Probation with probation beginning on January 1, 2002 and ending January 1, 2004. On January 1, 2004, Probation was completed and Respondent's certificate was fully restored.

JURISDICTION

4. This First Amended Accusation is brought before the Medical Board of California (Board[1]), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

[1] The term "Board" refers to the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Board. (Bus. & Prof. Code §2002)

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

7. Section 2234 of the Code states:

> "The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].
>
> "(b) Gross negligence.
>
> "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> "(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> "(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> "(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.
>
> "(f) Any action or conduct which would have warranted the denial of a certificate."

8. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to a patient constitutes unprofessional conduct.

9. Section 2242(a) of the Code provides that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

10. Section 2241.5 of the Code, The Intractable Pain Treatment Act, states, in pertinent part:

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

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

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

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

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

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

". . . .

". . . .

". . . .

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

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

" . . . ."

GUIDELINES FOR THE TREATMENT OF INTRACTABLE PAIN

11. Based upon the requirements of Business and Professions Code section 2241.5, the Medical Board of California adopted the following Guidelines for the Treatment of Intractable Pain in July 1994:

"1. HISTORY/PHYSICAL EXAMINATION. A thorough medical history and physical examination must be accomplished.

"2. TREATMENT PLAN/OBJECTIVES. The treatment plan should state

objectives by which treatment success can be evaluated, such as pain relief and/or improved physical and psychosocial function, ad indicate if any further diagnostic evaluations or other treatments are planned. Several treatment modalities or a rehabilitation program may be necessary.

"3. INFORMED CONSENT. The physician should discuss the risks and benefits of controlled substances with the patient or guardian.

"4. PERIODIC REVIEW. The physician should periodically review the course of opioid treatment of the patient and any new information about the etiology of the pain. Continuation or modification of opioid therapy depends on the physician's evaluation the progress toward treatment objectives.

"5. CONSULTATION. The physician should be willing to refer the patient as necessary for additional evaluation and treatment to achieve treatment objectives. Physicians should give special attention to those pain patients who are at risk for misusing their medications. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction specialists, and may entail the use of agreements between the provider and the patient to specify rules for medication use.

"6. RECORDS. The physician should keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews.

"7. COMPLIANCE WITH CONTROLLED SUBSTANCES LAW AND REGULATIONS. To prescribe substances, the physician must be appropriately licensed in California and comply with federal and state regulations for issuing controlled substance prescriptions. Documented adherence to these guidelines will substantially establish the physician's responsible treatment of patients with intractable pain and will serve to defend that treatment practice in the face of complaints which may be brought."

DRUGS INVOLVED

12. Actiq, a trade name for oral transmucosal fentanyl citrate, is a solid formulation of fentanyl citrate, a potent opioid analgesic intended for oral transmucosal administration. It is indicated for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Actiq is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance under Health and Safety Code section 11055(c)(8). Fentanyl is a pure-opioid agonist that can produce drug dependence of the morphine type, and thus, Actiq is subject to misuse, abuse, and addiction.

13. Acetaminophen is an over-the-counter non-steroidal anti-inflammatory drug indicated for the treatment of mild to moderate pain. The primary side effect of this medication is liver

toxicity, and the maximum daily dosage for long-term use should not exceed four (4) grams per day. Acetaminophen is often combined with opioid pain medications to enhance pain relief, so caution should be exercised in prescribing such combination medications to assure that safe levels of acetaminophen are not exceeded. In such combination products, acetaminophen is designated "APAP."

14. Adderall, a trade name for the combination of dextroamphetamine sulfate, amphetamine sulfate, dextroamphetamine saccharate, and amphetamine aspartate (also referred to generically as mixed amphetamine salts or amphetamine salt combo), is indicated for the treatment of attention deficit hyperactivity disorder (ADHD), mainly in children and adolescents, as an integral part of a total treatment program (psychological, educational, social) to help achieve a stabilizing effect. Adderall XR (extended release) is a formulation of Adderall designed to deliver a double-pulse of amphetamines, thus prolonging the release of amphetamines. Adderall is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance under Health and Safety Code section 11055(d)(1). Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. Manifestations of chronic intoxication with amphetamines include marked insomnia, irritability, hyperactivity, and personality changes, even psychosis indistinguishable from schizophrenia.

15. Alprazolam, trade name Xanax, is a psychotropic triazolo analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance and narcotic under Health and Safety Code section 11057(d)(1). Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs 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.

16. Clonazepam, trade name Klonopin, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 of the Code and a Schedule IV controlled substance Health and Safety Code section 11057(d)(7). It produces CNS depression and should be used with caution with other CNS depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of Klonopin.

17. Dextromethorphan is an antitussive found in many over-the-counter (OTC) cough/cold medications. Taken in large amounts, dextromethorphan produces euphoria, dissociation and other serious side effects, including death.

18. Gabapentin, trade name Neurontin, is indicated as adjunctive therapy in the treatment of partial seizures with and without secondary generalization adults with epilepsy. It is a dangerous drug as defined in section 4022 of the Code.

19. Hydrocodone bitartrate is produced by several drug manufacturers. Hydrocodone with APAP (acetaminophen) is known by the trade name "Tylenol #3" or "Tylenol #4. 5 mg. hydrocodone with 500 mg acetaminophen is known by the trade name "Vicodin" ("5/500"). 7.5 mg hydrocodone with 750 mg acetaminophen is known as "Vicodin ES" ("7.5/750"), and at 10 mg. strength, it is known as "Vicodin HP" or "Norco ("10/325"). Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 of the Code and a Schedule III controlled substance under Health and Safety Code section 11056(e)(4). Alcohol and other CNS depressants may provide an additive CNS depression if taken concomitantly with hydrocodone bitartrate. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence. Hydrocodone is also contained in varying amounts in preparations sold under the trade names Vicoprofen, Vicotuss, Lortab, Lorcet, and Zydone.

20. Librium, a trade name for chlordiazepoxide HCl, is a benzodiazepine and a CNS depressant indicated for the management of anxiety disorders, for the short-term relief of symptoms of anxiety, for withdrawal symptoms of acute alcoholism, and for preoperative apprehension and anxiety. It is a dangerous drug under section 4022 of the Code and a Schedule

IV controlled substance under Health and Safety Code section 11057(d)(5). Long term or excessive use of Librium can cause dependency.

For the relief of withdrawal symptoms of acute alcoholism, the parenteral form is usually used initially. If administered orally, the suggested initial dose is 50 to 100 mg to be followed by repeated doses as needed until agitation is controlled, up to 300 mg per day. Dosage should then be reduced to maintenance levels.

Side effects of Librium include drowsiness, ataxia, and confusion, particularly in elderly and debilitated patients. In such patients, it is recommended that the dosage be limited to the smallest effective amount to preclude the development of ataxia or oversedation (10 mg or less per day, initially, to be increased gradually, as needed and tolerated). In general, concomitant administration of Librium and other psychotropic medications is not recommended. It may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving or operating machinery. Concomitant use of alcohol or other CNS depressants may have an additive effect.

21. Lorazepam, trade name Ativan, is a benzodiazepine and central nervous system (CNS) depressant indicated for the management of anxiety disorders or for the short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug under section 4022 of the Code and a Schedule IV controlled substance under Health and Safety Code section 11057(d)(16). Side effects of Ativan include drowsiness, dizziness, lack of coordination headache, nausea, dry mouth, and blurred vision. Concomitant use of alcohol or other CNS depressants may have an additive effect. Lorazepam is not recommended for use in patients with primary depressive disorders. Lorazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. Sudden withdrawal from Lorazepam can produce withdrawal symptoms including seizures.

22. Lunesta, a trade name for eszopicione, is a short-acting non-benzodiazepine sedative hypnotic indicated for the treatment of chronic insomnia. It is a dangerous drug as defined in

section 4022 of the Code, and in federal regulations, it is listed as a Schedule IV controlled substance. Lunesta is contraindicated in patients with a history of depression, mental illness, or drug or alcohol addiction. Benzodiazepine-like drugs such as Lunesta may lead to psychological and physical dependence, and the risk increases with the length of treatment and is greater in patients with a history of drug or alcohol abuse.

23. Maxitrol is a trade name for a eye drops with active ingredients consisting of two antibiotics, neomycin and polymixin B sulfate and a corticosteroid, dexamethasone. It is used to treat infections of the eye, with the antibiotics controlling sensitive bacteria in the eye the steroid reducing inflammation. Maxitrol is contraindicated in most viral diseases of the eye and fungal diseases of ocular structures. It is also contraindicated in individuals with hypersensitivity to dexamethasone or other corticosteroids. Acute infections of the eye may be masked by or activity enhanced by the presence of corticosteroid medication. Use of corticosteroids may exacerbate glaucoma or the severity of viral infections of the eye, including herpes simplex. Maxitrol is a dangerous drug as defined in section 4022 of the Code.

24. Megace ES, a trade name for megestrol acetate, is a synthetic derivative of the steroid hormone progesterone. It is indicated for the treatment of anorexia, cachexia, or an unexplained significant weight loss in patients with AIDS. Therapy with Megace ES should only be instituted after treatable causes for weight loss, such as malignancy, systemic infection, or renal disease, are sought and addressed. Megace ES is a dangerous drug under section 4022 of the Code.

25. Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine; it is used in the treatment of moderate to severe pain. It is also used to prevent withdrawal symptoms in patients who are addicted to opiate drugs and are enrolled in treatment programs in order to stop taking or continue not taking the drugs. Methadone can produce drug dependence of the morphine type and therefore, it has the potential for abuse. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics. Methadone

inhibits cardiac potassium channels and prolongs the QT interval in heart rhythm. It should be administered with particular caution in patients at risk for development of prolonged QT interval, such as those with a history of cardiac conduction abnormalities, those taking medications affecting cardiac conduction, or those where history or physical examination indicate an increased risk of dysrhythmia. QT abnormalities have been reported in patients with no prior cardiac history who have received high doses of methadone. Cardiovascular status of patients on methadone should be assessed initially and monitored on electrocardiogram (EKG) for QT prolongation and dysrhythmias. Methadone is marketed under the trade names Dolophine and Methadose.

26. Oxycodone/APAP, a combination of oxycodone and acetaminophen, trade name Endocet or Percocet, is a narcotic analgesic indicated for the treatment of moderate or moderately severe pain. Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(N). is a CNS depressant and produces additive effects when taken in conjunction with other CNS depressant such as alcohol and other opiates. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

27. Oxycontin, a trade name for oxycodone hydrochloride controlled-release tablets, is a pure agonist opioid, the principal therapeutic action of which is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a white, odorless crystalline powder derived from the opium alkaloid, thebaine. It is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 of the Code and an Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055(b)(1). Oxycodone can produce drug dependence of the morphine type and therefore has the potential for being abused. Delayed absorption, as provided by Oxycontin, is believed to reduce the abuse liability of the drug.

28. Promethazine with codeine syrup, trade name Phenergan VC with codeine, is a combination of promethazine hydrochloride, phenylephrine hydrochloride, and codeine phosphate. It is an antiemetic, antihistamine, and antitussive indicated for the temporary relief of cough and other upper respiratory symptoms. Phenergan` is a dangerous drug as defined in section 4022 of the Code which has antihistaminic, sedative, anti-motion sickness, antiemetic, and anticholinergic effects. The concomitant use of alcohol, sedative hypnotics (including barbiturates), general anesthetics, narcotics, narcotic analgesics, tranquilizers or other CNS depressants may have additive sedative effects and patients should be warned accordingly. Phenergan may significantly affect the actions of other drugs. It may increase, prolong, or intensify the sedative action of CNS depressants. Phenylephrine is an OTC antihistamine. Codeine is combined with promethazine for its antitussive effect and is a dangerous drug under section 4022 of the Code and a Schedule V controlled substance and narcotic under Health and Safety Code section 11058(c)(1). Codeine is a drug of abuse, although its abuse potential is low in this combination. However, it must be administered under close supervision to those with a history of drug abuse or dependence.

29. Provigil, a trade name for modafinil, is an analeptic drug and a stimulant indicated for the treatment of narcolepsy, shift work sleep disorder, and excessive daytime sleepiness associated with obstructive sleep apnea. Off-label or experimentally, it has been used in the treatment of adult Attention Deficit Hyperactivity Disorder (ADHD), depression, bipolar depression, opiate and cocaine dependence, Parkinson's disease, schizophrenia, and disease-related fatigue, as well as fatigue as a side effect of other medication. It is contraindicated in persons with cardiovascular disease or other cardiac conditions, particularly while using other stimulants and for persons with cirrhosis. It should not be taken with alcohol. Modafinil is a dangerous drug as defined in section 4022 of the Code and a Schedule IV controlled substance under Health and Safety Code section 11057(f)(3).

30. Risperdal, a trade name for risperidone, is an antipsychotic agent and a benzisoxazole derivative indicated for the management of the manifestations of psychotic disorders. Patients taking Risperdal must be closely monitored for signs and symptoms of neuroleptic malignant

syndrome, tardive dyskinesia, orthostatic hypotension, seizures, and somnolence. Risperdal is a dangerous drug under section 4022 of the Code.

31. Suboxone, a trade name for a combination of buphrenorphine hydrochloride and naloxone hydrochloride, is indicated for the treatment of opioid addiction. Buphrenorphine is an opioid similar to morphine, codeine, and heroin; however, it produces less euphoria and therefore may be easier to stop taking; it is a Schedule V controlled substance under Health and Safety Code section 11058(d). Buphrenorphine is used for maintenance during or after opiate withdrawal. Naloxone blocks the effects of opioids such as morphine, codeine, and heroin (opioid agonist) and therefore blocks the effects of buphrenorphine withdrawal. Buphrenorphine can cause drug dependence of the morphine type. Under the Drug Addiction Treatment Act DATA), codified at 21 U.S.C. section 823(g), prescription use of Suboxone in the treatment of opioid dependence is limited to physicians who meet certain qualifying requirements and have notified the Secretary of Health and Human Services (HHS) of their intent to prescribe the product for the treatment of opioid dependence and have been assigned a unique treatment number that must be included on every prescription. This "DATA Waiver" allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the U.S. Food and Drug Administration (FDA). Suboxone received FDA approval for use in opioid addiction therapy in October of 2002.

Subutex, a trade name for buphrenorphine hydrochloride, is approved for use in medication-assisted opioid addiction therapy, but unlike Suboxone, it is not combined with naloxone to block the effects of opioids. Thus, it is used primarily for its long-term opioid effects in aiding opioid withdrawal.

32. Temazepam, trade name Restoril, is a benzodiazepine hypnotic agent indicated for the short-term treatment of insomnia. It is a dangerous drug as defined in section 4022 of the Code and a Schedule IV controlled substance under Health and Safety Code section 11057(d)(29). Patients using Restoril should be warned about the possible combined effects if taken concomitantly with alcohol and other CNS depressants. Side effects of Restoril include drowsiness, headache, fatigue, lethargy, and dizziness.

33. Trazodone, trade name Desyrel, is a triazolopyridine antidepressant which increases concentrations of serotonin in the brain, but is not a selective serotonin reuptake inhibitor (SSRI). Trazodone is indicated for the treatment of depression, but also prescribed as an anxiolytic or a sedative. The chief side effect of trazodone is drowsiness. Trazodone increases the effects of alcohol and narcotic pain medications. It is a dangerous drug as defined in section 4022.

34. Ultram, a trade name for tramadol hydrochloride, is a centrally acting opioid analgesic, a synthetic analog of the phenanthrene alkaloid codeine. It is indicated for the management of moderate to moderately severe chronic pain in adults who require around-the-clock management of pain for an extended period of time. In patients taking other CNS depressants such as other opioids, tramadol should be given in reduced dosages in that danger of respiratory depression is increased. There is a risk of seizures and convulsions in patients taking tramadol. Tramadol, like other opioids, can be abused and may cause physical dependence or addiction. Tramadol may be expected to have additive effects when used in conjunction with alcohol, other opioids, or illicit drugs that cause CNS depression. Tramadol is a dangerous drug as defined in section 4022 of the Code.

35 Xenical, a trade name for orlistat, is a drug designed to treat obesity. Its primary function is to prevent the absorption of fats from the human diet, thereby reducing caloric intake. It is intended for use in conjunction with a physician-supervised reduced-calorie diet. Orlistat also moderately reduces blood pressure and appears to prevent the onset of type 2 diabetes. Orlistat is contraindicated for persons with malabsorption, reduced gallbladder function, impaired liver function or pancreatic disease. Primary side effects are oily, loose stools, fecal incontinence, and frequent or urgent bowel movements. Orlistat is a dangerous drug as defined in section 4022 of the Code.

36. Zolpidem tartrate, trade name Ambien, is a non-benzodiazepine hypnotic of the imidasopyridine class. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance under Health and Safety Code section 11057(d)(32). It is indicated for the short-term treatment of insomnia. It is a CNS depressant and should be used cautiously in combination with other CNS depressants. Any CNS depressant could potentially enhance the

CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

37. The acts or omissions charged in the First through Seventh Causes for Discipline herein occurred in 2006 and 2007 while respondent was acting as a physician for skilled nursing facilities, Pine Ridge Care Center and Country Villa Healthcare Center in San Rafael, California (Accusation filed June 17, 2010). The acts or omissions charged in the Eighth through Sixteenth Causes for Discipline occurred from 2005 continuing on through 2011 and involved respondent's private practice.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence - Patient H.A.[2])

38. Respondent is subject to disciplinary action under section 2234(b) and/or (c) and/or (d) of the Code in that he was grossly negligent and/or repeatedly negligent and/or incompetent in his care and treatment of Patient H.A. The circumstances are as follows:

39. Patient H.A., a 91 year-old male, was admitted to Marin General Hospital on September 29, 2006 after a fall at his assisted living facility. During his hospitalization, H.A. became agitated and was managed with Risperdal and Ativan and diagnosed with "dementia with agitation." H.A. had been hospitalized for five days when he was transferred to Pine Ridge Care Center on October 3, 2006. The Marin General transfer note to Pine Ridge listed pertinent diagnoses as dementia, B12 deficiency, hypertension, and hypothyroid and recommended that H.A.'s activity be supervised. Marin General included H.A.'s admitting history and physical with its transfer report. The history and physical made no mention of alcoholism and in fact stated in the social history portion that H.A. had never been a heavy drinker or even a significant social drinker. It also noted that H.A. was dehydrated according to admitting laboratory results. The

---

[2] Patients' true names are not set forth herein in order to protect patient privacy. Respondent will be provided with patient names pursuant to his request for discovery in this action.

transfer report noted that H.A. was an aspiration risk. Respondent was in charge of H.A.'s care at Pine Ridge and was aware that Marin General recommended that H.A. have a "sitter." P.B., H.A.'s daughter, held H.A.'s Durable Power of Attorney for Health Care. On admission to Pine Ridge, H.A. was agitated and at times combative, but alert and responsive.

40. Respondent first saw H.A. on October 5, 2006. His admitting history and physical is very brief and partially illegible. Respondent documents H.A.'s history as including "multiple falls, [marked?] tremors/ataxia, noted confabulation, tangential ideation, lives alone, hypothyroidism, ? head injury." The diagnosis section states, "ataxia/tremor, **prob. chr alcoholism** c U/E ecchym & shin tear." (Emphasis added.)

41. H.A.'s primary care physician had prescribed psychoactive medications for agitation which were administered by Marin General before transfer to Pine Ridge, which medications were Ativan, Restoril and Risperdal. Although Pine Ridge prepared informed consent for H.A. to take these medications, these were not signed by P.B. During H.A.'s stay at Pine Ridge, no further informed consent for psychoactive medication was obtained. H.A. was not assigned a "sitter" until his last days at Pine Ridge.

42. On October 5, 2006, H.A. was also seen by psychiatric nurse practitioner M.H., who noted H.A.'s agitation and combativeness, read respondent's diagnosis of probable chronic alcoholism and the general diagnosis of dementia, and concluded that H.A. suffered from alcohol-induced persistent dementia, cerebral degeneration, organic affective syndrome, and dementia with behavioral disturbance. M.H. had a telephone consultation with her supervising psychiatrist, who recommended discontinuing Restoril and Ativan and beginning Librium 100 mg every 6 hours for 24 hours, then 75 mg every six (6) hours for two (2) days, then 50 mg every 6 hours for one week. Respondent approved this regimen for treatment of H.A.'s "alcohol withdrawal." However, respondent did not specifically discontinue H.A.'s Restoril or Ativan.

43. H.A became increasingly sedated on his medication regimen at Pine Ridge, and P.B. expressed concern over his sedation and was told that it was treatment for H.A.'s alcohol withdrawal. P.B. asked that the medications be discontinued because her father had never been an alcoholic or even a heavy drinker. Respondent spoke with P.B. on October 9, 2006, and P.B.

demanded that all sedating medications be stopped, but respondent indicated they were necessary for detoxification from alcohol. Respondent only indicated that he would reevaluate H.A.

44. Respondent saw H.A. on October 10, 2006. The nursing notes indicated that H.A. was sleepy, but cooperative with but one episode of agitation in the morning. Nursing notes indicate that one hour after that notation, respondent increased H.A.'s Librium to 50 mg QID despite P.B.'s request and his own observation that H.A. was "awake with arousal" and "sedated." Respondent also noted that P.B. wanted medication at the lowest level to do the work. With no documented reason, on October 12, 2006, respondent decreased the Librium from 50 mg QID to 25 mg TID.

45. On October 14, 2006, P.B. contacted respondent and indicated that H.A. was not eating, that he was having trouble swallowing, and that he seemed dehydrated. Respondent saw H.A. on October 14, 2006 and noted that H.A. was "arousable, eyes closed" and "dehydrated." Respondent did not document any assessment of swallowing or gag reflex. Respondent ordered staff to "give fluid juice/water continuously" and that staff could "use tracheal suction for tracheal mucus." Staff successfully administered 300 cc of water by mouth.

46. By the morning of October 15, 2006, H.A. was unresponsive; he had a high fever and a very low oxygen saturation. He was transferred to Marin General Hospital where he was treated for aspiration pneumonia and altered mental status. Although respondent gave a telephone order for H.A.'s transport to Marin General on a nursing report that H.A. could not be aroused, there is no indication that respondent ordered that any Pine Ridge treatment notes or prepared summary of care to be sent to Marin General on transfer. H.A. made no significant recovery and died in the hospital on November 8, 2006. Urine testing for Librium and its metabolites remained positive for two weeks into his hospitalization, and initial EEG suggested metabolic slowing.

47. Respondent is guilty of gross negligence and/or repeated acts of negligence and/or incompetence in his care and treatment of patient H.A. by reason of the following acts or omissions:

a. Respondent failed to review, note, and understand the medical information provided by Marin General Hospital on H.A.'s transfer to Pine Ridge on October 3, 2006 as part of his initial evaluation of H.A., and he failed to provide his own clinical information on H.A. when he ordered him transferred back to Marin General Hospital on October 15, 2006.

b. Respondent diagnosed H.A. with chronic alcoholism on observation of ataxia, confabulation, and tangential ideation without review or understanding of the transfer papers from Marin General, which indicated very limited alcohol intake, and without assessment or examination for acute alcohol withdrawal. Respondent failed to note that the symptoms could be indicative of many other disorders, that H.A.'s pulse and blood pressure were normal on transfer (which would not have been the case if he were in alcohol withdrawal), and that the symptoms noted did not begin on admission to Pine Ridge, but were observed, diagnosed, and treated at the hospital before transfer. Respondent also did not understand that confabulation is not a symptom of alcohol withdrawal.

c. Respondent prescribed Librium in tapering doses for H.A.'s alcohol withdrawal syndrome when he had no basis for the diagnosis, when P.B. indicated, as did hospital records, that H.A. hardly drank alcohol at all, and when he knew or should have known that high doses of Librium in a 91 year old man is highly dangerous. Respondent lacked knowledge or ability in the correct diagnosis of alcohol withdrawal syndrome and in the potential consequences of treating an elderly non-alcoholic with a regimen of Librium that is only recommended for alcohol withdrawal.

d. Respondent failed to use psychotropic medication in a skilled nursing facility setting only when necessary for a specific condition, in the lowest effective dose, and after obtaining informed consent. There was no informed consent for the use of Librium on H.A.'s chart or in H.A.'s file at Pine Ridge or any indication of a discussion with P.B. regarding its purpose or her right to refuse treatment on behalf of her father. Respondent failed to consider behavioral interventions and efforts to discontinue the drug even when indicated by H.A.'s excessive sedation and the fact that indications were that H.A. was not suffering from acute alcohol withdrawal.

e. Respondent continued to use high doses of Librium in the face of multiple observations that the patient was sedated. In the face of nursing notes, physical and occupational therapy notes, and respondent's own notes that H.A. was heavily sedated, as well as P.B.'s repeated complaints that H.A. was overmedicated, respondent did not stop the use of Librium, even increasing its dosage in one instance directly after P.B. had requested that the medication be stopped.

f. Respondent ordered oral fluids to be administered to H.A. on October 14, 2006 despite the fact that H.A. had to be roused to a wakeful state and the fact that P.B. had informed him that H.A. could not eat and was having trouble swallowing. Respondent failed to assess H.A.'s ability to swallow and to protect his airway before ordering fluids to correct his dehydrated state by oral administration. Respondent failed to appreciate that administration of 300 cc of fluid in one shift was grossly inadequate to correct dehydration in any case.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without Examination/Medical Indication – Patient H.A.)

48. The allegations of the First Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

49. Respondent is subject to disciplinary action under sections 2242(a) and 2234 of the Code in that he prescribed Librium for H.A. without appropriate prior examination and medical indication. Respondent diagnosed H.A. with acute alcohol withdrawal and prescribed high doses of Librium appropriate only for the treatment of alcohol withdrawal without first consulting the transfer records from Marin General Hospital, without examining H.A. to rule out other causes for the patient's ataxia, tremors, dementia, and confabulation and confirm his diagnosis, and without carefully considering dosages appropriate to H.A.'s advanced age.

THIRD CAUSE FOR DISCIPLINE

(Inadequate/Inaccurate Records-Patient H.A.)

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

51. Respondent is subject to disciplinary action under sections 2266 and 2234 of the Code in that his records for H.A. are inadequate and inaccurate. Respondent's records for H.A. are generally illegible and are significantly inaccurate as regards H.A.'s alleged history of alcoholism. There was nothing in H.A.'s transfer records to suggest alcoholism, and P.B. insisted that her father had no history of excessive drinking. Respondent's diagnosis of "chronic alcoholism" was picked up by the behavioral medicine nurse practitioner and used as the basis for a treatment recommendation using levels of Librium that would only be used in the setting of acute alcohol withdrawal. Respondent had ample opportunity to seek corroboration of this diagnosis, but he declined to revisit it and persisted in basing his treatment on his original erroneous diagnosis.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient M.B.)

52. Respondent is subject to discipline under section 2234(b), (c), and/or (d) in that he was grossly negligent and/or repeatedly negligent and/or incompetent in his care and treatment of patient M.B. The circumstances are as follows:

53. From 2006 through 2008, respondent was the medical director of Country Villa San Rafael skilled nursing facility (formerly Hillside Care Center). Respondent was also a house physician, acting as primary care physician for a portion of the residents. As director, he assumed care for indigent patients. One of his patients was M.B., a long-term female resident with both mental and physical disabilities; M.B. was 57 years of age in 2007. M.B.'s physical disabilities were the result of multiple major fractures sustained in a suicide attempt and a seizure disorder which developed after the removal of a benign brain tumor in 1985. M.B. also had a number of psychiatric diagnoses, including conversion reaction, schizophrenia, bipolar disorder, and depression. For M.B.'s chronic intractable pain resulting from her fractures, respondent prescribed Oxycontin 40 mg BID and Vicodin #240 per month prn breakthrough pain.

54. On June 5, 2007, M.B. had a psychotic episode and was transferred to Marin County Psychiatric Emergency, which placed M.B. on a 72 hour hold. While there, M.B. fell and broke her left leg and was admitted to Alta Bates Hospital, where she was found to have a mid-shaft

tibia/fibula fracture, as well as extensive diffuse osteopenia. On June 7, 2007, a closed reduction of the fracture was performed, and she was placed in a patellar tendon bearing cast. It was noted that M.B. had an intramedullary rod in the left femur with four distal fixation screws from an earlier injury. The discharge summary indicated that her weight-bearing status was touchdown weight-bearing to the left lower extremity and gradually increasing. She was to follow up with the orthopedic surgeon in his office.

55. On June 8, 2007, M.B. was transferred to the Herrick Hospital psychiatric unit, where she remained until June 25, 2007. The admission note indicated M.B. had previous bilateral knee surgery and bilateral wrist surgery related to jumping episodes or previous suicide attempts. She was evaluated by physical therapy. M.B. was found to be somnolent on the level of Oxycontin prescribed by respondent, so this was reduced to 20 mg. BID and then held entirely due to somnolence. Discharge summary from the psychiatric unit indicated that M.B. was to remain on non-weight-bearing status and follow up with the orthopedist within 30 days post discharge. It indicates her mental diagnoses on discharge were "Axis I, schizoaffective disorder, depressed, r/o factitious disorder, Axis II, borderline personality disorder."

56. On June 25, 2007, M.B. was readmitted to Country Villa, and respondent reassumed responsibility for her care as her primary care physician. Respondent saw M.B. on June 26, 2007 and made an admitting note indicating her return to Country Villa. Respondent's admitting note makes no mention of M.B.'s cast in his physical examination, stating only "no edema, weakness" on his extremities examination. Respondent's assessment was "Much weight decreased with cachexia, chronic pain sx, recent colles fracture, multiple trauma, depression, psychosis." A colles fracture is a fracture of the wrist, not of the leg. Respondent's plan for treatment consisted of "cont. all pain and psychotropic drugs" written in the margin. He does not mention nor have any plan for the Foley catheter that M.B. had in place on transfer; his examination of the genitalia is noted as "atrophic" with no mention of a catheter in place. Respondent presented no therapeutic plan for dealing with M.B.'s cachexia and weight loss, although five (5) weeks later, he did order Megace ES for cachexia.

57. There are no physician's progress notes for M.B. from April 24, 2007 until November 28, 2007, when respondent wrote an "Interval General Medical Note" in which respondent says his progress notes have not been found but reiterates dates on which nursing notes appear to indicate he saw M.B.[3] Respondent avers that an appointment was made for M.B. to see the orthopedic surgeon in early July but that she refused to go. Respondent also avers that he referred M.B. to local orthopedists for follow up, but that they refused to see her due to her Medi-Cal status. There is no notation in M.B.'s records either by respondent, in nursing notes, in social service staff notes or any other record for M.B. that these referrals were made or that they were refused by M.B. or the physicians to whom referrals were made. Respondent stated at his physician conference with the Medical Board on September 14, 2009 that he had removed the cast himself on November 6, 2007, but there is no confirmation of this action in M.B.'s medical records. There is only a notation in the social service notes that M.B. had refused to go to an appointment for cast removal scheduled with an orthopedic surgeon on November 6, 2007 and that Dr. Seet had removed the cast himself on that date.

58. During the seven (7) month period for which respondent had no physician's progress notes for M.B., nursing notes indicated respondent's activities with respect to M.B. as:

a. May 19, 2007: "in the facility with new order"

b. June 4, 2007: "came and informed resident sent to hospital for resident psychotic behavior"

c. June 26, 2007: "seen by Dr. Seet"

d. August 19, 2007: "Dr. Seet made visit with new orders"

e. August 26, 2007: "Dr. Seet here ordered psych eval"

f. September 26, 2007: "Dr. Seet came with new order of treatment"

g. October 14, 2007: "Dr. Seet has come by today and undersigned (illegible) referral about resident's L lower cast. Dr. Seet has seen and talked to resident and noted order for

---

[3] On November 20, 2007, the Department of Public Health issued to Country Villa a Class A citation for delayed removal of M.B.'s cast; the "Interval General Medical Note" was made eight (8) days after the citation was issued.

discontinuing order for Vicodin tab p.o. Q (illegible) PRN and ordered to make an appointment with ortho surgeon for removal of L leg short cast."

There are no nursing notes in M.B.'s records between the October 14th note and November 9, 2007.

59. There is a fax request from nursing to Dr. Seet in the record dated September 3, 2007 in which a nurse requested, "May we have an orthopedic consult for her long leg cast f/u?" Respondent answered in the affirmative to this request. However, there is no notation prior to October 14, 2007 of any affirmative order by respondent to refer M.B. to an orthopedic surgeon for removal of her cast. There is no notation in the record of any plan by respondent for the evaluation of M.B.'s healing fracture, interim care, and timely removal of M.B.'s cast with follow up evaluation and physical therapy.

60. Respondent apparently removed the cast himself on November 6, 2007, but there is no notation in the record indicating that this was done except for a note in the social services record that M.B. refused to keep an appointment with an orthopedic surgeon on November 6, 2007, and respondent removed the cast himself. After removal of M.B.'s cast, radiological studies to evaluate healing of the fracture were not ordered until November 25, 2007, and it is unclear whether respondent ordered the x-rays.

61. During the seven month period for which there are no physician's notes for M.B., physician's orders indicate that respondent prescribed topical antibiotics for a 2 cm. abscess of M.B.'s thigh, and in early November 2007, when M.B. had a sty, respondent prescribed Maxitrol drops. After readmission, respondent again increased the amount of narcotics given to M.B. without documenting any examination, reason for the increase, or response to therapy.

62. During his physician conference with the Medical Board on September 14, 2009, respondent stated that part of his role as medical director of Country Villa was to call or write doctors if they failed to see their patients and to see the "indigent" (Medi-Cal) patients. When asked if he agreed with the Department of Public Health that a medical director is "responsible for patient care policy and coordination of care," respondent replied, "They don't pay me enough for that." As to M.B., respondent stated that her records came with her from the hospital and

acknowledged that he never spoke with the orthopedist who had set M.B.'s leg fracture, and stated that he reviewed the record, saw M.B. for "10, 15, 25 minutes" and encouraged her to take her medications. He described his treatment plan as "supportive care." He claimed that admitting orders are "pre-written" and that he just signed them. He acknowledged that the discharge summary specified orthopedic follow up with the orthopedist who had set M.B.'s leg fracture, but that he did not write an order for that because he expected social work and nursing to do that. When respondent was asked about why he did not document anything concerning M.B.'s cast or a plan of care for it on his admitting note, respondent replied that he thought he was overwhelmed because M.B. had so many other issues.

63. When informed that he was under Medical Board investigation for his care and treatment of M.B., respondent had M.B., a severely mentally disabled person still dependent upon him for care, write a witnessed letter of support on his letterhead dated June 21, 2009. In her own handwriting, M.B. discussed her medical condition, respondent's medical care for her, and the fact that she wanted to keep respondent as her doctor.

64. Respondent is guilty of gross negligence and/or repeated acts of negligence and/or incompetence in his care and treatment of patient M.B. by reason of the following acts or omissions:

a. Respondent failed to consult with the orthopedist who repaired M.B.'s fracture to coordinate necessary follow up care and to implement the care plan established by the specialist. This is not the province of nursing or social work, as respondent stated, but the responsibility of the primary care physician. When the patient refused follow up orthopedic care, there is no documentation of any discussion with M.B. as to the risks of refusing care, and there is no indication that the orthopedist was consulted as to possible alternatives such as x-rays taken at a closer facility and delivered to the orthopedist to determine timing of when to remove the cast. After removing the cast, respondent did not consult with the orthopedist and did not arrange for timely follow-up x-rays and assessment. Respondent's failure to coordinate care for M.B.'s leg fracture repair, his statement that he was not paid enough to coordinate this patient's care, and his

failure to take responsibility for M.B. remaining in a cast for five (5) months constitute unprofessional conduct and an extreme departure from the standard of practice of medicine.

b. Respondent prescribed Megace for M.B.'s cachexia. There is no indication of any work up to determine the cause of the weight loss and initiation of treatment based upon the cause. Megace is generally reserved for patients with AIDS wasting or weight loss from cancer.

c. M.B. was readmitted to Country Villa with a Foley catheter in place. Respondent failed to note this and to assess M.B. for removal of the catheter as soon as possible to reduce the risk of urinary tract infection. The catheter was not removed until four (4) weeks after readmission to Country Villa, and that was at the patient's request.

d. Respondent failed to document an examination and evaluation when prescribing and altering the amount of narcotics for M.B.'s chronic pain.

e. Respondent failed to assess M.B. and determine whether incision and drainage or systemic antibiotics were necessary to treat M.B.'s thigh abscess. Application of topical antibiotics is not indicated for the treatment of infected cysts or abscesses.

f. Respondent prescribed Maxitrol for M.B.'s sty based on a telephone description of her problem. Maxitrol contains steroids and antibiotics, and the steroid carries the risk of exacerbating some eye conditions and should not be used unless the eye has been examined and the diagnosis requires it.

g. M.B. was mentally disabled and remained respondent's patient when respondent asked her to write a letter of support for him to help in the investigation against him. It is inappropriate to ask any patient to write such a letter in this context, but it is grossly unprofessional to have asked a patient such as M.B. to do so. Respondent blurred the boundaries between physician and patient when M.B. herself, diagnosed with borderline personality disorder, had severe challenges in maintaining appropriate boundaries.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Examination/Medical Indication – Patient M.B.)

65. The allegations of the Fourth Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

66. Respondent is subject to disciplinary action under sections 2242(a) and 2234 of the Code in that:

a. He prescribed Megace for M.B.'s cachexia without workup as to the cause of the weight loss or indication for the use of a medication generally reserved for AIDS wasting and weight loss from cancer.

b. He increased the amount of M.B.'s narcotics for her chronic pain without documentation of any examination, assessment or indication for the increase and without any follow up assessment of therapeutic effect.

c. He prescribed Maxitrol for M.B.'s sty without first examining the eye and diagnosing the exact condition of the eye before determining that a medication containing steroids was indicated for the diagnosis.

SIXTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Records – Patient M.B.)

67. The allegations of the Fourth Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

68. Respondent is subject to disciplinary action under sections 2266 and 2234 of the Code in that:

a. There are no physician's progress notes in M.B.'s Country Villa records between late April and early November 2007. There is no corroborating evidence in other notes in the record that monthly visits were made to M.B. or that respondent paid any attention to M.B.'s leg cast before October of 2007. Respondent avers that his progress notes for this period were lost and bases his summary of care, entered on November 28, 2007, on nurses' notes during that period; yet, nurses notes that mention respondent, except in two or three instances, do not indicate actual visits to M.B.

b. Respondent's admission note for June 26, 2007 is inaccurate. It makes no note of M.B.'s leg cast and in fact states that she had a "colles" fracture, which is a fracture of the wrist. His psychiatric diagnoses for M.B. on admission do not correlate in any way with the discharge

diagnoses on the transfer summary from the psychiatric hospital. There is no mention of the Foley catheter in place in his examination of the genitalia.

///

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient M.H.)

69. Respondent is subject to disciplinary action under section 2234(b) and/or (c) and/or (d) of the Code in that he was grossly negligent and/or repeatedly negligent and/or incompetent in his care and treatment of patient M.H. The circumstances are as follows:

70. On or about October 6, 2009, M.H., a 22 year old male consulted Respondent. No reason for the visit to Respondent in lieu of M.H.'s regular pain physician or any referral was noted. M.H. was experiencing continuing pain after left-shoulder arthroscopic surgery and development of left shoulder arthritis and the development of a paralabral cyst and associated tearing of the labrum in his right shoulder. M.H. indicated he was taking methadone for the pain associated with these shoulder conditions and that he would like to up his dose of methadone because he was still experiencing a lot of pain; he indicated decreased overall function due to pain. He described his pain as 8-9/10 in intensity, with the least pain experienced as 5/10. Blood pressure (BP) was 136/86; Pulse 106. M.H. completed a medical pain history and list of medications he was currently taking. He listed his current medication as methadone, 10 mg, four times or more daily, and past medications as naproxen, aspirin, ibuprofen, Percocet, Darvocet, and Oxycontin. Respondent performed a physical examination. Respondent prescribed tramadol (Ultram) 50 mg. #30, 1/2 *bid*; gabapentin (Neurontin) 60 mg. #30, 1/2 at bedtime for 7 days, and *bid* for pain block; and methadone 10 mg. #100, 2 every 6-8 hours.

71. Respondent next saw M.H. on October 19, 2009. A history was taken and a physical performed. Respondent noted a goal as 4-5 methadone tablets a day. BP was 106/74; Pulse 108. Pain was described as reduced to 2-3/10. Respondent prescribed methadone 10 mg. #90, 2 every 8 hours; tramadol 50 mg. #100, 1 every 8 hours; and added Norco 10/325 #45, 1 every 6 hours. There was no notation as to why Norco was initiated.

72. Respondent next saw M.H. in follow-up on November 3, 2009. Respondent noted a goal to decrease methadone to 40 mg. per day from the 60 to 70 mg. M.H. was taking. A brief physical examination was done. Pain remained decreased in intensity; BP was 120/70; Pulse 100. A urine drug screen was ordered. M.H. tested positive for methadone and tramadol, as well as oxycodone and oxymorphone. M.H. apparently explained the oxycodone/oxymorphone results as from Percocet prescribed by another physician. At a December 3, 2009 appointment, M.H. indicated that he took Percocet (not prescribed by Respondent) when he ran out of methadone at five per day. Respondent prescribed methadone 10 mg. #180, 2 every 8-9 hours and gabapentin 600 mg. #100, 1/2 every 8 hours.

73. Respondent next saw M.H. on December 3, 2009. Pain was noted as 2/10. BP was 123/96; Pulse 100. Noted were decreased range of motion, crepitus, and other motor findings with regard to M.H.'s shoulder. The results of the urine drug screen were reviewed. M.H. had tested positive for methadone and tramadol, but also for oxycodone and oxymorphone. M.H. explained that the oxycodone/oxymorphone results were from Percocet, which was not prescribed by Respondent. M.H. explained that he took Percocet when he ran out of methadone at five per day. Apparently not inquiring further or contacting the prescriber of the Percocet, Respondent prescribed methadone 10 mg. #150, 1 every 4-6 hours; tramadol 50 mg. #90, 1 every 8 hours, breakthrough pain; and Norco 10/325 #90, every 8 hours breakthrough pain.

74. Respondent next saw M.H. on January 4, 2010. Pain was noted as 4.5/10; BP 125/78; Pulse 98. Respondent prescribed methadone 10 mg. #150, 1 every 4-6 hours and gabapentin 600 mg. #100 (instructions unclear). There is a notation in the chart that M.H.'s mother called on January 20, 2011 and informed Respondent that M.H. "took too much meds." Apparently M.H. had overdosed on drugs and had to be hospitalized. Respondent noted at the bottom of the January 4, 2010 progress notes, "D/C from clinic. Cover for emergency."

75. Respondent did not see M.H. again until January 26, 2011, when the patient presented indicating that he had been taking heroin and oxycodone on his patient registration form. No reason for the visit was entered. M.H. signed a pain medication agreement, and a Clinical Opiate Withdrawal Scale (COWS) was done, with a final score of 6 (mild withdrawal symptoms). M.H.

noted that he had been treated at Mountain Vista Farms in February/March 2010. Respondent took no history of the year interval since he had last seen M.H., so no information was obtained concerning his treatment program and its outcome, of other treatment programs, other attempts at drug withdrawal, other illicit drugs used besides heroin, and any hospital stays. Medical progress notes by Respondent indicated present illness as right shoulder pain with pain now 1.5/10 and past history as "dependent on narcotics s/p arthro surg 10/10." Respondent diagnosed stable right shoulder pain and narcotic dependence. Respondent prescribed Suboxone #30, 1/2 every 8 hours, with follow up in two weeks. There was apparently no follow up visit.

76. At no time during his treatment of patient M.H. did Respondent obtain a release of information authorization for M.H.'s previous or concurrent physicians, contact M.H.'s previous or concurrent physicians, or search the CURES program for information related to previous or concurrent controlled substance prescriptions for M.H. At no time during his treatment of patient M.H. did Respondent obtain an EKG, advise M.H. of the cardiac dangers of methadone treatment, or advise him of the need to avoid other medications that would potentiate the adverse effects of methadone. At no time during his treatment of patient M.H. did Respondent obtain information from his previous or concurrent physicians concerning previous EKG's they may have performed prior to or in the course of treatment of M.H. with methadone.

77. Respondent is guilty of gross negligence and/or repeated acts of negligence and/or incompetence in his care and treatment of M.H. by reason of the following acts or omissions:

a. Respondent took an inadequate history and performed an inadequate physical examination before prescribing controlled substances for pain. He did not include assessment of M.H.'s pain, physical and psychological function, a substance abuse history, history of prior pain management, or assessment of the underlying or coexisting disease or conditions.

b. Respondent's treatment plan did not include objective measurements by which treatment goals could be evaluated, such as improvement of psychological and physical function, and did not include plans for any further diagnostic evaluations or treatment. He did not tailor M.H.'s treatment to the patient's individual medical condition.

c. Respondent failed to obtain a release of information for M.H.'s prior or concurrent treating physicians. He failed to contact M.H.'s previous or concurrent treating physicians to obtain treatment information or consult or coordinate with them. Respondent did not consult CURES for information concerning previous or concurrent controlled substance prescriptions for M.H., even when M.H. informed Respondent he was taking controlled substances prescribed by other physicians when methadone was not adequate to control his pain.

d. Respondent repeatedly prescribed methadone for M.H. without warning him of the potential health consequences associated with its use or following FDA guidelines and did not monitor M.H. appropriately for such potential complications. He failed to provide M.H. with an informed consent regarding potential side effects of methadone, including sleep apnea, testosterone insufficiency, cardiac arrhythmias, and addiction.

e. After more than a year had passed since Respondent saw M.H., Respondent prescribed Suboxone as an opioid maintenance program for a patient with an addiction problem. Respondent failed to take an interim addiction history or an interim drug treatment history, nor did he document any discussion as to why Suboxone maintenance was indicated. There was no documentation of an addiction problem in M.H.'s treatment records.

EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient J.B.)

Background of Patient J.B.

78. J.B. is a female adult approximately 27 years of age. In 2004 and 2005, she resided in Santa Clara County. In 2004, J.B. was convicted of passing false checks, a felony, and sentenced to three years probation. In 2005, she was convicted of felony possession of a controlled substance, methamphetamine, and felony vehicle theft. J.B. was sentenced to serve three years probation, concurrent with the previous conviction. In 2006, she was convicted of being under the influence of a controlled substance, methamphetamine, a misdemeanor, and sentenced to two years probation.

79. In approximately mid-2005, J.B. relocated to Marin County and commenced medical treatment with Respondent. In March of 2007, J.B. and Respondent were married in a private

ceremony. Respondent and J.B. resided at the same address in Novato, California at all times pertinent to the facts alleged hereafter.

80. In May of 2008, J.B. was arrested by the Novato Police Department for driving under the influence of alcohol ("DUI"). J.B. had lost control of her vehicle and crashed into the home of a neighbor across the street and had run into her residence. When police entered the Seet residence, J.B. was there, as well as her passenger and other residents at her home address. J.B. failed field sobriety tests. She was arrested and charged with DUI, hit-and-run, and in August of 2008 in Marin County Superior Court, J.B. was convicted, pursuant to plea, of misdemeanor DUI and sentenced to 36 months probation. Her driver's license was suspended.

81. In October of 2008, J.B. was stopped and cited by the Novato Police Department for failure to obey a traffic signal and for driving while having a suspended driver's license.

82. In late October of 2008, an anonymous tip was called into the Petaluma Police Department indicating that J.B. was selling narcotics out of her place of work, a hair salon. A policeman observed what appeared to be a drug sale outside of the salon, and he followed the purchaser of the drugs as he entered a vehicle and drove away. The vehicle was stopped for a routine equipment violation, and J.B. was the driver of that vehicle. J.B. was arrested for driving with a suspended license and giving false information to a police officer. A search incident to the arrest revealed a bag containing drug paraphernalia, marijuana, and a baggie containing what later was confirmed to be methamphetamine, and $459.00 in U.S. currency. J.B. was booked at Petaluma Police Department for possession for sale of methamphetamine, transportation of methamphetamine, as well as the initial charges. A felony complaint was filed against J.B. in Sonoma County Superior Court in December 2008 alleging possession of methamphetamine for sale, a felony; unlawful transportation of methamphetamine, a felony; falsely identifying herself to a police officer, a misdemeanor; and driving on a suspended license.

83. In November of 2008, J.B. (as well as others present at her home), was arrested at her residence by the San Rafael Police Department for being under the influence of a controlled substance, methamphetamine. A search warrant was executed at J.B. and Respondent's home on suspicion of possession of controlled substances for sale, as evidenced by the arrest described in

paragraph 81, above. At the residence, police discovered drug paraphernalia, a number of "pay/owe" slips in the names of various persons, and evidence of methamphetamine use. An arrest warrant was issued by Sonoma County Superior Court late December 2008, and in March 2009, in a negotiated plea, pleaded guilty to a violation of Health and Safety Code section 11377(a) (Unlawful Possession of a Controlled Substance), a felony. In April, 2009, J.B. was sentenced to 36 months formal probation with terms which included a program of treatment (where she was ordered to continue with and remain in a solid recovery program in Petaluma), a program of counseling, registering as a narcotics offender (Health and Safety Code section 11590), DNA testing, and warrantless searches. In July of 2009, J.B.'s probation was summarily revoked, and she was taken into custody; at a hearing, J.B. was released to Marin County Probation for placement in a residential treatment program when space becomes available; in the interim, J.B. was to remain in custody. In August of 2010, J.B. was released from custody to be transported to treatment at a treatment facility.

84. In February 2009, a complaint was filed in Marin County Superior Court charging J.B. with being under the influence of methamphetamine, a misdemeanor. This stemmed from the search warrant incident of November 2011 described in paragraph 81, above. In May of 2009, J.B. pleaded guilty to the charges and was placed on supervised probation for three years under Penal Code section 1210.1 (Proposition 36). As conditions of probation, J.B. was required to participate in a drug treatment program and in a therapy group; she was ordered to register as a narcotics offender; she was ordered not to use, transport, or possess any non-prescribed or illegal drugs or associated paraphernalia; and she could be drug tested at any time. Later that month, a petition to revoke probation was filed due to a drug related violation of probation and a charge of first treatment failure. In May of 2009, J.B. tested positive for alcohol at a random screening in April 2010. J.B. was ordered to stay and participate in the treatment program. The Petition to Revoke Probation was held in abeyance pending no further treatment failures.

85. In November of 2009, J.B. tested positive for amphetamine in a random drug screening. In January of 2010, during a probation search at her Novato home, J.B. was found in possession of 52 grams of marijuana. J.B. produced a medical marijuana card issued by

Respondent, her husband, who was present. In January of 2010, a further Petition to Revoke Probation was filed. A hearing was held in March 2010, where the Petition was dismissed, and J.B. was ordered to remain in the treatment program and be subject to random testing.

86. In June of 2010, a further Petition to Revoke Probation was filed in the Marin County action based on J.B.'s second treatment failure. In August of 2010, when J.B. was in custody in Sonoma County, and the Marin County Superior Court ordered J.B. to report to probation on release from Sonoma County and provide the court with an assessment report.

87. A further Petition to Revoke Probation was filed in the Marin County action in July of 2010 based on J.B.'s third treatment failure, a drug-related violation. At the time of filing, J.B. was in custody in the Sonoma County action. In July of 2010, during a probation search at her home, she was found in possession of methamphetamine and drug paraphernalia. Respondent was present. J.B. was then in custody in Sonoma County. At a hearing, in August of 2010, paralleling the Order of Sonoma County Superior Court, J.B. was ordered to go into the residential treatment program arranged by Sonoma County probation or be terminated from the Proposition 36 program. In September of 2010, probation was reinstated, and J.B. was again ordered into treatment.

Respondent's Treatment of Patient J.B.

2005

88. On or about May 20, 2005, Respondent undertook to care for and treat J.B. J.B. filled out a new patient form and submitted some of her adolescent medical records. J.B.'s medical history included recurrent headaches and a diagnosis of attention deficit hyperactivity disorder (ADHD) for which Adderall had been prescribed at a clinic in Yakima, Washington beginning in 1995 and ending in 1999, when J.B. was between 11 and 15 years of age. After 1999, Adderall was not prescribed for J.B. but Ritalin and Paxil had been prescribed until 2001. No stimulant medications for ADHD had been prescribed to J.B. since 2001, and Adderall had not been prescribed since 1999. Respondent prescribed Imitrex and Adderall at this first visit. No examination or testing for migraine headaches or adult ADHD or referral to an appropriate

specialist is noted in Respondent's record. Shortly after this first appointment, Respondent and J.B. commenced residing together at his home in Novato.

89. Respondent inserted into J.B.'s medical record an undated letter on his letterhead addressed "To Whom it May Concern" in J.B.'s medical record stating that J.B. is on Adderall and her urine will be positive for amphetamines if tested. A Summary of Patient History dated June 29, 2005 was provided to Women's Correctional Facility in San Jose indicating that J.B. has a long standing history of ADHD and that she needs Adderall to function. Respondent had knowledge of J.B.'s arrest and conviction in 2005 for felony possession of a controlled substance, methamphetamine.

90. According to Respondent's records, J.B.'s next office visit was on September 8, 2005. J.B. had gained weight and it is noted that the Women's Correctional Facility discontinued her Adderall. Respondent prescribed Adderall and Xenical (orlistat). A Summary of Patient History was sent to Santa Clara Medical Facility on October 2, 2005 for no specified reason. In December 2005, a letter from Bayside Marin indicates that Respondent was inquiring into sober living environments for J.B.

2006

91. J.B.'s next office visit was January 9, 2006. She is listed as 21 years of age, and Respondent had her fill out a New Patient Form. Respondent indicated in J.B.'s history that she had ADHD and had been on Adderall for four years and on Ritalin since childhood. He indicated that her medications were Adderall and Xenical. He also indicated that J.B. was status post drug rehabilitation for unrelated medications. Respondent diagnosed ADHD by history and ADHD as well as exogenous obesity and prescribed Adderall and Xenical. J.B. was referred for tummy tuck surgery. J.B.'s next visit was on October 14, 2006 with a finding of fluid accumulation in the abdomen and pain. Impression was seroma, status post paniculectomy, and the site was aspirated.

92. **The CURES (Controlled Substance Utilization and Evaluation Program, California's Prescription Drug Monitoring Program) Patient Activity Report ("PAR") for J.B. for January through October 2006 indicates that in January 2006, Respondent**

prescribed amphetamine salt combo (Adderall) 10 mg. #25. In March 2006, the dose was 20 mg. and the number increased to 120. In May 2006, Adderall XR 20 mg. was initiated. There is no documentation in J.B.'s chart for the change in formulation. In September 2006, Respondent prescribed Actiq, a rapid-acting form of fentanyl, to J.B., as well as Ambien. In October 2006, Respondent prescribed APAP oxycodone to J.B. There is no documentation in J.B.'s record indicating that these controlled substances were prescribed or any medical indication for the prescriptions.

2007

93. J.B. consulted Respondent at his office only once in 2007, according to Respondent's records, on August 10, 2007. This appears to be a wellness check. It is indicated that J.B. is on Adderall 20 mg. daily x three months.

94. **The CURES PAR for J.B. for February through December 2007 indicates that in February 2007, Respondent prescribed amphetamine salt combo #30 for J.B. There is no documentation in J.B.'s record of the reason for the change in formulation from Adderall XR back to amphetamine salts. In April 2007, Respondent increased the number of tablets of amphetamine salts 30 mg. prescribed to #100, with no documentation of the reason for this increase. In August 2007, amphetamine salt combo 30 mg. #90 was prescribed.**

95. **J.B.'s CURES PAR for February through December 2007 also indicates that Respondent prescribed the following controlled substances for J.B. with no documentation in the record that they were prescribed or the rationale for prescribing them: APAP/Hydrocodone 500/5 #20 in March 2007; temazepam (Restoril) 15 mg. #10 in March 2007; Lunesta 3 mg. #30 or #37 in April, May, October and December 2007; Oxycontin 40 mg #30 and Oxycontin 40 mg. #20 on the same day in July 2007; zolpidem (Ambien) 10 mg. #30 in October 2007.**

2008

96. J.B. consulted Respondent in January 2008 with complaints of acute abdominal pain and vomiting. Respondent diagnosed acute cholecystitis apparently based on her mother's medical history and a physical examination. Respondent prescribed Toradol and a reduced fat

diet. In J.B.'s records is a May 2008 laboratory report on drugs of abuse from Marin General Hospital indicating a test positive for amphetamines for J.B. The test was related to J.B.'s arrest of May 2005 DUI/hit and run arrest described above in paragraph 79, above.

97. **The CURES PAR for J.B. for January through May 2008 indicates that Respondent prescribed amphetamine salt combo #60 to J.B. in January, February, and May 2008, with no indication in the record of its continued prescription or the rationale for the continued prescription. Respondent prescribed the following controlled substances for J.B. with no documentation in the record that they were prescribed or the rationale for prescribing them: Alprazolam (Xanax) 2 mg. #45 in January 2008 and #15 in May 2008; Lunesta 3 mg. #30 in January, February, and May 2008; Zolpidem (Ambien) 10 mg. #15 in January 2008; APAP/oxycodone 325/10 #30 in March 2008; oxycodone 30 mg. #45 and #5 in April 2008.**

98. J.B. was seen in Respondent's office on June 1, 2008 with a chest wall contusion from a motor vehicle accident (MVA), presumably from the car crash into her neighbor's house on May 30, 2008 which resulted in her DUI arrest. Respondent found left breast ecchymoses and a locally tender sternum, as well as a possible breast implant rupture. A chest X-ray was negative. Tylenol, Advil, and ice pack were recommended. J.B. was seen again on June 22, 2008. She completed a diabetic flow chart and complained of inability to sleep at night. She apparently suffered from anxiety over her probable left breast implant rupture. Respondent noted referral to a psychiatrist for anxiety and a plastic surgeon for the breast implant rupture. On July 12, 2008, J.B. again saw Respondent complaining of continuing breast pain from the MVA. She had seen the plastic surgeon and immediate surgery could not be done; she remained anxious. Respondent prescribed alprazolam 2 mg. #30 and Advil. J.B. next consulted Respondent on August 7, 2008, requesting help with a prior authorization for an MRI from her plastic surgeon. Respondent has in the record a report from the plastic surgeon dated September 10, 2008 on a bilateral breast MRI order by the plastic surgeon indicating no breast implant rupture. Respondent saw J.B. after this report on September 12, 2008. Breast assymetry from the MVA

was noted as well as the negative MRI. Respondent's impressions were mastitis and costochondritis. He prescribed alprazolam (Xanax) 2 mg. #30 and Ambien (zolpidem) 10 #20.

99. In Respondent's 2008 records for J.B. were the following: Petaluma Police Department report on the October 23, 2008 traffic stop and discovery of drug paraphernalia, methamphetamine, and marijuana; October 29, 2008 incident report from Novato Police Department indicating citation for driving on a suspended license; November 7, 2008 incident/investigation report from Petaluma Police Department indicating results of search warrant served and executed at Respondent and J.B.'s residence and J.B.'s arrest for possession of methamphetamine/marijuana for sale and being under the influence of controlled substances.

100. J.B.'s last visit with Respondent in 2008 was on November 26. Respondent lists MVA, assymetry of breast implants, costochondritis, insomnia, migraine headaches, and anxiety from rupture of implants as indications for the visit. He prescribed Advil, 600 mg. Adderall #30, and Ambien (zolpidem)10 mg. #40.

101. **The CURES PAR for J. B. for June through November 2008 indicates that Respondent prescribed amphetamine salt combo 30 mg. #60 in June, July, September, and October of 2008, and mixed amphetamine salts, 30 mg. #60 in August and November of 2008. He noted a prescription for Adderall in November 2008 in J.B.'s records, and no rationale was given for the continued prescription of amphetamines in light of J.B.'s arrests for methamphetamine possession and intoxication and her court-ordered drug treatment. Respondent prescribed the following controlled substances for J.B. with little or no documentation in the record that they were prescribed or the rationale for prescribing them: Alprazolam (Xanax) 2 mg. #60 in June 2008; APAP/oxycodone 325/10 #20 in July and #60 in October 2008; Lunesta 3 mg. #20 in July 2008; zolpidem (Ambien) 10 mg #20 in August, October, and November 2008; in September 2008 sedative hypnotics Alprazolam 2 mg. #20 and #45 and zolpidem (Ambien) 10 mg. #20; temazepam (Restoril) 15 mg. #30 in October 2008, Oxycontin 80 mg. #60 in October 2008; APAP/hydrocodone bitartrate 325/10 #20 in November 2008.**

2009

102. J.B.'s first office visit to Respondent was on April 25, 2009. Respondent listed her present illness as ADHD and mentions her having been on Adderall since 2001. He also lists, costochondritis post MVA, and migraine headache. By the record, Respondent prescribed Provigil 200 mg. #30 for J.B.'s ADHD as he was "unable to Rx Adderall." In the side margin of J.B.'s chart next to this entry, Respondent had the following notations with no explanation: "5/29/09-alprazolam 2 #30; [illegible] 5/500 A#30; 5/6/09 zolpidem #20; 5/31/09-Adderall 20 #60; 5/20/09 phenter 37.5; 5/25/09-alprazolam #45 ½ q12h; 4/29/09 [illegible]."

103. **The CURES PAR for J.B. for January through April 2009 indicates that Respondent prescribed Provigil for J.B. four times under the same prescription number and J.B. filled the prescriptions on March 31, 2009 (2 tablets), April 2, 2009 (2 tablets), April 3, 2009 (1 tablet), and April 4, 2009 (5 tablets), all well before the April 25, 2009 office visit. In that time period, Respondent prescribed the following controlled substances for J.B. with no documentation in the record that they were prescribed or the purpose for which they were prescribed: alprazolam 2 mg. #30 in January 2009; zolpidem 10 mg. #30 in January 2009 and #20 in March 2009; mixed amphetamine salts 30 mg. #60 in January 2009; Lunesta 3 mg. #20 in January 2009.**

104. J.B.'s next office visit to Respondent in 2009 was on May 31, 2009. J.B. complained about inability to focus, disorganization, and faulty memory. Respondent's diagnosis was that she needed Adderall. He diagnosed ADHD, costochondritis, and migraine headache. He apparently prescribed Adderall 30 mg. #60. In the lower right hand corner of the form, Respondent noted "5/28/09-alprazolam #30. In J.B.'s chart was a Novato Police Department report detailing an incident in June 2009 where J.B. was cited for operating a motor vehicle without an ignition interlocking device as ordered by the Court.

105. J.B. next saw Respondent in his office on October 30, 2009. Respondent diagnosed ADHD, costochondritis, and migraine headache and prescribed Adderall 30 mg. #60, Tylenol/Advil 5-7 per day, and Imitrex 100 mg. #4. The last office visit in 2009 was on December 20, 2009, where J.B.'s present illness was listed as "sober months." Respondent's

diagnoses were chronic costochondritis, ADHD, and vascular headache. J.B.'s chart indicates a recommendation for Adderall 30 mg. bid.

106. **The CURES PAR for J.B. for May through December 2009 indicates that Respondent prescribed for J.B. phentermine HCl 37.5 mg. #20, APAP/Hydrocodone 500/5 #30, and alprazolam 2 mg. #30 in May 2009; amphetamine salt combo, 30 mg. #60, and alprazolam 2 mg. #30 in August 2009; amphetamine salt combo, 30 mg. #60 in September 2009; mixed amphetamine sales 20 mg. #60 in November 2009; and amphetamine salt combo 30 mg. #60 in December 2009. Although Respondent's margin notes and other notes in J.B.'s chart for 2009 indicate a few of these prescriptions, notably phentermine HCl, APAP/hydrocodone, and alprazolam 2 mg. #30 in May 2009 and Adderall/mixed amphetamine salts in November 2009, the remainder are not accounted for in the record and the drugs named in the chart have no rationale for the prescriptions documented. Prescriptions not listed in the CURES report but listed in J.B.'s chart may indicate prescriptions that J.B. did not fill or after-added entries with errors in the drugs named.**

2010

107. Records available indicated that J.B. had an office visit with Respondent on January 8, 2010 for acute recent vaginal bleeding. Respondent's plan was to order a pelvic sonogram, prescribe Premarin, and refer to a specialist. **The CURES PAR for J.B. for 2010 indicates that Respondent prescribed amphetamine salt combo 30 mg. #30 in January 2010. There is no notation in J.B.'s chart of this prescription.**

108. Respondent is subject to discipline under sections 2234 and 2234 (b), (c), and/or (d) of the Code in that he is guilty of unprofessional conduct and/or gross negligence and/or negligence and/or incompetence in his care and treatment of patient J.B. by reason of the following acts or omissions:

a. Respondent prescribed controlled substances, including amphetamines, hypnotics, and narcotics, for a person with whom he had an intimate relationship predating any prescription, whom he married in 2007, and with full knowledge of the fact that she had abused and was

addicted to amphetamines. He failed to refer her to another physician for management of medical conditions which he felt entailed the necessity for treatment with controlled substances.

b. Respondent prescribed amphetamines, including Adderall, amphetamine salt combo, and mixed amphetamine salts with full knowledge that the patient had abused and was addicted to methamphetamine. He continued to prescribe amphetamines even though more than once during Respondent's treatment, J.B. was arrested, convicted, and ordered to drug rehabilitation for methamphetamine possession, possession for sale, and being under the influence of methamphetamine.

c. Respondent prescribed amphetamines to J.B. for ADHD without examination and diagnosis. J.B. had been diagnosed with childhood ADHD, and when she consulted Respondent, she was an adult and had not taken Adderall for ADHD for more than four (4) years. Respondent did no work up to determine whether J.B. suffered from adult ADHD or refer her out to a psychiatrist for testing and diagnosis, nor did he entertain differential diagnoses, such as addiction or antisocial personality disorder, before assuming adult ADHD and prescribing amphetamines.

d. To the extent Respondent likened ADHD to diabetes or thyroid disease in that just as lifelong insulin is required for diabetics and thyroid hormone for thyroid disease, he exhibits a lack of knowledge that childhood ADHD does not always result in adult ADHD and that these disorders are treated differently. Lifetime amphetamines are not required to treat adult ADHD, especially in a patient addicted to methamphetamine.

e. Respondent failed to consider alternatives to amphetamines to treat adult ADHD such as tricylic antidepressants or bupropion, for a patient who he knew had abused and was addicted to methamphetamine.

f. To the extent Respondent may have been treating J.B. for her addiction by prescribing stimulant controlled substances, there is no such drug treatment protocol for methamphetamine addiction, and there is no documentation in J.B.'s record that this was the case. Moreover, when J.B. was arrested for methamphetamine use despite Respondent's prescriptions, indicating that any such addiction treatment protocol was ineffective, Respondent continued prescribing amphetamines.

g. Respondent increased the number of Adderall pills prescribed to J.B. within a certain time period without any rationale or documentation in the record for the change.

h. Respondent prescribed narcotic controlled substances to J.B. other than amphetamines with no rationale for their use or any consistent documentation in the record of the prescriptions. For example, in September 2006, Respondent prescribed Actiq, a rapid-acting form of fentanyl; in October 2006, APAP/oxycodone 325/10 and in March 2007, APAP/oxycodone 500/5; and Oxycontin 40 mg in July 2007, a very high initial dose of Oxycontin. There is no indication in Respondent's records as to any examination, diagnosis, or medical indication noted, or any rationale for the high doses prescribed.

i. Respondent prescribed hypnotic controlled substances for J.B. with no documentation of the prescriptions or any examination to confirm a medical indication for the prescriptions. For example, Respondent prescribed temazepam 15 mg. in March 2003; Lunesta 3 mg. in April 2007 and May 2007 with no documentation of prescriptions, diagnosis, or medical indication noted.

j. Respondent diagnosed costochondritis in J.B. four months after her motor vehicle accident in May 2008, when he found a locally tender sternum, and continued with this diagnosis through October of 2009. Costochondritis is a benign, usually self-limiting, condition which is treated with non-steroidal anti-inflammatory agents and only rarely with narcotic pain killers or muscle relaxants. There is no indication that Respondent performed any examination to confirm this diagnosis or considered any differential diagnosis. To the extent that Respondent attributes his prescriptions for narcotics and hypnotics to this condition, he failed to document any examination or testing to confirm costochondritis or any rationale for the prescription of narcotic pain killers or hypnotics, the notations for which he placed in the margins of J.B.'s record without accuracy.

k. Respondent documents no discussion with J.B. concerning treatment with amphetamines, narcotic analgesics, or hypnotics prior to prescribing, no written contract detailing expectations, no informed consent, and no follow up notes indicating functional improvement or lack of aberrant behavior as signs of progress in treatment.

NINTH CAUSE FOR DISCIPLINE

(Prescribing without Examination/Medical Indication – Patient J.B.)

109. The allegations of the Eighth Cause for Discipline are incorporated herein by reference as if fully set forth.

110. Respondent prescribed dangerous drugs and controlled substances to J.B. without appropriate examination and medical indication and therefore is subject to disciplinary action under sections 2242(a) and 2234 of the Code in that:

a. He prescribed amphetamines for J.B. without examination or testing to confirm or rule out adult ADHD, without consideration of medications other than those to which J.B. was addicted and without documentation of any progress on the medication. He continued to prescribe amphetamines after it was obvious that J.B. was addicted to amphetamines and sought to obtain more by illegal means.

b. He prescribed narcotic analgesics for J.B. without examination or testing to determine an accurate diagnosis or medical indication. The dosages of the narcotics prescribed were large and could have been fatal. In some cases, narcotic analgesics were prescribed with no indication in the record at all for the prescription or any notation of the prescription.

c. He prescribed hypnotics for J.B. without examination or testing to determine an accurate diagnosis or medical indication.

TENTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Records – Patient J.B.)

111. The allegations of the Eighth Cause for Discipline are incorporated herein by reference as if fully set forth.

112. Respondent kept inaccurate and inadequate medical records for J.B. and therefore is subject to disciplinary action under sections 2266 and 2234 of the Code in that:

a. Respondent's records for J.B. were sketchy, illegible, and inaccurate in that he failed to record all prescriptions for narcotic and hypnotic controlled substances which he had issued to her and had failed to document a full history, particularly an addiction history, physical examination, differential diagnosis, diagnosis, or rationale for the prescribing of such substances. He failed to document any treatment plan.

b. Respondent consistently prescribed amphetamines to J.B. without documentation in the record of any examination or testing for ADHD for which he reportedly prescribed them. Other than J.B.'s juvenile records from Washington, which J.B. provided to him, Respondent did not document any release or communication with any of J.B.'s prior health or concurrent treatment providers.

c. Respondent failed to document follow up findings on J.B.'s prescriptions, particularly for amphetamines, to warrant continuation of the drugs.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient M.F.)

113. On or about May 8, 2007, Respondent undertook to care for and treat Patient M.F., a 22 year old male, M.F. filled out a patient history form. Under medical history, M.F. listed groin pain and headaches; he listed his current medications as Oxycontin, Vicodin, and multivitamins. He listed lower back pain (LBP) as a current complaint. Under substance abuse, he listed alcohol and marijuana, past and current use. M.F. also filled out a pain comfort assessment guide wherein he described aching, shooting stabbing, gnawing, penetrating and miserable pain interfering with all aspects of life, relieved only by Celebrex and pain medications. M.F. had apparently provided to Respondent a copy of right groin sonogram dated 12/07/2005 indicating a palpable 7 x 4 cm. right groin mass with clinical assessment of "abscess vs. lymphadenopathy, erythema, and swelling." M.F. also provided Respondent a copy of a normal CT brain scan dated 05/10/2000. There is no indication of Respondent's having obtained releases of information from M.F. to follow up on these findings or to obtain any other treatment records or consultations for his treatment of this patient.

114. Respondent filled out a pain assessment form with a diagnosis of lower back pain from a football injury in Nevada and weight gain. Pain location was listed as right anterior groin, right mid and lower back, and left anterior lateral head, and the present intensity was listed as 8/10. Under "What relieves the pain," Respondent listed Celebrex 200 *bid.* Respondent listed the treatment as pain control. Respondent also prepared a checklist for long-term opioid therapy in which he concluded that there was medical indication for use of Vicodin. He completed a patient

physical examination form. To the side of the form, Respondent listed Celebrex 200 daily and Norco q 6h. Records for May 8, 2007 include a copy of a prescription for trazodone #20, 1 *qhs*. Respondent did not have M.F. sign a pain treatment contract or order a drug screen. At no time during his treatment of M.F. for intractable pain did Respondent order a CURES report or a drug screen.

115. **The CURES PAR for M.F. indicates that on May 8, 2007, M.F. filled prescriptions from Respondent for APAP/hydrocodone 325/10 #60 (generic for Norco) and APAP/oxycodone 325/10 #20 on May 8, 2007. The CURES report for M.F. also indicates that another physician had prescribed APAP/hydrocodone 10/325 #50 three times in March 2007, twice in April 2007, and once on May 7, 2007, the day before M.F. first consulted Respondent. Respondent did not did not seek releases or obtain records and information from M.F.'s previous and concurrent medical providers before prescribing narcotic pain medication for M.F.**

116. On May 13, 2007, M.F. was arrested by the Petaluma Police Department for driving under the influence of alcohol, and on August 24, 2007, he was convicted and placed on 36 months probation. It is unclear from Respondent's records whether this arrest was disclosed to him, but M.F. had indicated in his patient history form that he abused alcohol and marijuana. There is no record that Respondent provided informed consent to M.F. concerning the risks of large amounts of acetaminophen-containing controlled substances in combination with alcohol affecting liver function.

117. M.F.'s next appointment was on May 21, 2007, where vital signs were taken and quality of pain was noted. Respondent notes "Norco 10/325 #120 1 *q5/7h*, gabapentin 100 2 *qhs*, HSL BID, Advil 600 mg, *bidx5*, RTC 4 weeks." **The CURES PAR for M.F. indicates that M.F. filled Respondent's prescription for APAP/hydrocodone 10/325 #50 on May 17, 2007. This prescription was not noted in M.F.'s records. It also indicates that M.F. filled Respondent's prescription for APAP/hydrocodone 10/325 #120 and clonazepam 0.5 mg #30 on May 21, 2007. Also, the report indicates that Respondent issued an APAP/hydrocodone 325/10 #20 prescription, which M.F. filled on May 25, 2007. Respondent did not check the**

CURES PAR and has no record of the clonazepam prescription or its medical indication and no notation of the prescriptions filled on May 17, 2007 in M.F.'s medical record.

118. M.F.'s next appointment was on May 30, 2007. Respondent entered a complaint of anxiety and inability to sleep due to recurrent intrusive thoughts. He entered an assessment of anxiety reaction and past medical history of headaches and "slip disc" for which an x-ray was needed. Respondent's plan indicated "Klonopin [clonazepam] 1 #50 1/2 *q*8h, psych eval if cont." The next appointment was on June 15, 2007. Respondent noted that an MRI was done with results pending but does not note who ordered the test or for what reason. He noted that M.F.'s lower lumbar vertebrae were tender with decreased range of motion. He noted that M.F. had chronic pain syndrome from his football injury and anxiety reaction since age 16 for which he received psychiatric care. He diagnosed muscle spasms and indicated a plan including Advil, Norco 10/325 *q*6h, gabapentin 100 *bid*, Percocet 10/325, and Klonopin 1 #30. He indicated the need for a psychiatric evaluation. **The CURES PAR for M.F. indicates that on June 15, 2007, M.F. filled prescriptions from Respondent for APAP/hydrocodone 325/10 #120, APAP/oxycodone 325/10 #30, and clonazepam (Klonopin) 1 mg #30. M.F. also filled a further prescription from Respondent for clonazepam 1 mg #30 on July 7, 2007, and this prescription is nowhere noted in Respondent's records for M.F. The report also indicates that M.F. filled another physician's prescriptions for APAP/hydrocodone 325/10 # 50 on June 13, 2007 and June 27, 2007.**

119. M.F.'s next appointment was on July 19, 2007. Respondent noted complaints of radiating pain, headaches, anxiety and that his lower back was locally tender. Respondent's plan included discontinuing gabapentin and Percocet 10/325 *q*12h and prescribing Oxycontin 20 mg. #20, Norco 10/325 *q*6h, and Soma 1 *bid prn*." **The CURES PAR for M.F. indicates that on August 6, 2007, M.F. filled Respondent's prescription for APAP/hydrocodone 325/10, #120 and on August 10, 2007, M.F. filled Respondent's prescription for another #120 APAP/hydrocodone 10/325. Respondent did not note indications for changing to Oxycontin in his notes and did not note the reasons for discontinuing Percocet and gabapentin.**

120. M.F.'s next appointment was on August 20, 2007. Respondent completed a physical examination form indicating that M.F.'s present illness was headaches, with a past history of groin pain secondary to a football injury. He notes that M.F.'s pain is now 7/10. Respondent notes "Oxycontin 20 *q*7h, Norco 10/325 Gaba 100 *q*6h, Advil 4 tabs 5/7 (illegible)." Dosage and number of tablets is not mentioned, except for OTC Advil. At the bottom of the page for this appointment, Respondent notes "10/30/07 Norco 10/325 (illegible)." **The CURES PAR for M.F. indicates that on August 20, 2007, M.F. filled two prescriptions issued by Respondent for APAP/hydrocodone 325/10 #120 and one for Oxycontin 20 mg #60.**

121. Respondent did not see M.F. in his office for more than a year after the August 20, 2007 appointment. M.F.'s next appointment with Respondent was on September 10, 2008. **The CURES PAR for M.F. indicates that between the August 20, 2007 appointment and the September 10, 2008 appointment, M.F. filled prescriptions from Respondent as follows: clonazepam l mg. #30 on 08/24/2007 and 11/28/2007; clonazepam 1 mg. #10 on 01/03/2008; APAP/hydrocodone 10/325 #120 on 09/11/2007, 10/03/2007, 10/22/2007, and 10/31/2007; and APAP/hydrocodone 10/325 #15 on 11/28/2007. The PAR also indicates that another physician prescribed lorazepam 1 mg. #30 and Subutex 2mg. #50 for M.F. and these were filled by M.F. on March 28, 2008, indicating M.F. was being treated for addiction. None of Respondent's interim prescriptions are recorded in Respondent's chart for M.F., except for APAP/hydrocodone of 10/30/2007, which was noted on the bottom of the August 20, 2007 progress note. At his physician conference with the Medical Board enforcement staff on February 17, 2011, Respondent indicated that he has postdated prescriptions for scheduled medications.**

122. At the September 10, 2008 visit, Respondent filled out a physical examination form indicating a herniated disc, headache, and a pain level of 7/10. Respondent did not inquire as to the medical events in M.F.'s life during the year since his last appointment. He did not inquire as to any other physicians he had seen or what controlled substances he was receiving from other physicians. He did not inquire concerning the name nor did he request records from the physician who diagnosed from an x-ray/MRI a herniated disc. Respondent did not order a drug screen or a

CURES report on M.F. **The CURES PAR for M.F. indicates that M.F. filled Respondent's prescriptions for Oxycontin 40 mg. #45 and APAP/oxycodone 10/325 #45 (Percocet) on September 10, 2008. The Oxycontin was double the previous dose prescribed and while there are copies of Respondent's prescription for Oxycontin and Percocet in M.F.'s records, Respondent did not document a rationale for the doubling of the Oxycontin dose. M.F.'s PAR also indicates that on September 11, 2008, M.F. filled Respondent's prescription for APAP/hydrocodone 325/10 #120, a prescription not specifically noted by Respondent in M.F.'s record.**

123. M.F.'s next appointment with Respondent was on September 25, 2008. Respondent indicates a physical examination, listing the present illness as lower back pain from a football injury with a past history of allergy to gabapentin, causing headaches. Respondent notes vital signs and pain level of 6/10 with the least being 5/10, a stiff neck and decreased range of motion. He notes in the right margin, Oxycontin 40 mg. #90, Percocet 10/325 #120, loose 20#, a 1000 calorie per day diet and the MRI of the lower spine. **The CURES PAR for M.F. indicates that M.F. filled Respondent's prescription for Oxycontin 40 mg #90 and APAP/oxycodone 10/325 #120 on September 25, 2008 but Respondent did not document a reason for prescribing double the number of Oxycontin pills and almost three times the number of Percocet pills.**

124. M.F.'s next appointment with Respondent was on November 4, 2008. Respondent recorded a physical examination. He noted present illness as lower back pain from a football injury, with a past history of allergy to gabapentin causing headaches. He noted pain level as 7/10, with the least being 4-5/10. He again noted the MRI showing a bulging disc in the lower back. He notes in the right margin, Oxycontin 40 mg. *q*8h, Percocet 10/325 *q*6-8h, 1000 calorie diet, needs orthopedic evaluation, and no insurance. He notes vital signs and examination of the neck, thorax, heart, abdomen, and genitalia/rectal, with an impression of lumbar discitis. There is a copy of a prescription for Oxycontin 40 mg. #90 *q*8h, Percocet 10/325 #120 *q*8h, and alprazolam 2 mg. #20 *q*18-24h in the record. There is no rationale for the alprazolam prescription documented. **The CURES PAR for M.F. indicates that on November 4, 2008, M.F. filled**

Respondent's prescriptions for alprazolam, Oxycontin, and APAP/oxycodone (Percocet). The PAR also indicates that on December 1, 2008, M.F. filled Respondent's prescriptions for alprazolam 2 mg, #20, APAP/oxycodone 325/7.5 #60, and Oxycontin 40 mg. #60. The prescription for alprazolam was not noted in the record. No reasons for the decrease in dosage of APAP oxycodone and the number of pills for both Oxycontin and APAP/oxycodone were documented. In M.F.'s medical record, Respondent has a copy of a prescription written to M.F. dated December 16, 2008 for Oxycontin 40 mg. #85 *q*8h and Percocet 10/325 #120 *q*6h, and the CURES PAR for M.F. indicates that on December 17, 2008, M.F. filled Respondent's prescriptions for Endocet 10/325 (APAP/oxycodone) #120 and Oxycontin 40 mg, #85. There is no explanation for this prescription in M.F.'s medical record.

125. M.F.'s next appointment with Respondent was on January 26, 2009. Respondent recorded a physical examination indicating the present illness as lower back pain from a football injury with a past history of allergy to gabapentin. He again notes the MRI of a bulging disc. Pain is noted as presently 5.5/10 and least pain as 4/10. Vital signs are recorded. Impression is lumbar discitis, bulging disc. Respondent indicated prescriptions for Oxycontin 40 mg, #90 *q*12h, Percocet 10/325 #120, and tramadol #50 *q*6h. **The CURES PAR for M.F. indicates that on January 29, 2009, M.F. filled prescriptions for Oxycontin 40 mg, #60 and #15. There is no explanation for the discrepancy in the number of pills or the fact that the prescriptions for Percocet and tramadol were apparently not filled.**

126. M.F.'s final appointment with Respondent was on March 9, 2009. Respondent recorded a physical examination with the same present complaint, lower back pain from a football injury and noting a gabapentin allergy and the MRI of the bulging disc. Pain is noted as 5.5/10 and least pain as 4/10. Vital signs are recorded. Respondent indicates that the lower back is tender and indicates a para spinal muscle spasm. Impression is lumbar discitis and bulging disc. Respondent indicates prescriptions for Oxycontin 40 mg, #85, Percocet 10/325 #120, and alprazolam 2 mg, 1/2*q* (illegible). **The CURES PAR for M.F. indicates that M.F. filled these prescriptions on March 9, 2009.**

127. Respondent's records for M.F. indicate that on March 10, 2009, Respondent was contacted by a pharmacy to inquire concerning two refills on a prescription for Norco 10/325 #120 apparently written by Respondent to M.F.'s brother. This was included in a prescription which also included Oxycontin 40 mg. #60 and alprazolam 2 mg, #30. On that same date, M.F. presented a prescription apparently written by Respondent to himself for Oxycontin 80 mg, #90 and alprazolam 2 mg, #60. Respondent verified that the prescriptions were falsified, and M.F. and his brother were arrested. A police search of M.F.'s residence yielded 487 narcotic pills, 229 marijuana plants, pay and owe records, and almost $7,000 in cash. M.F. admitted to police that he was addicted to oxycodone.

128. Respondent is subject to discipline under sections 2234(b) and/or (c) and/or (d) of the Code in that he is guilty of gross negligence and/or negligence and/or incompetence in his care and treatment of patient M.F. by reason of the following acts or omissions:

a. Respondent did not discuss with M.F. the dangers of acetaminophen toxicity and continued to prescribe large doses of acetaminophen-containing controlled substances to M.F., for many months in a patient who admitted to continuous alcohol use.

b. Before prescribing opioids on a long-term basis and in high doses, Respondent failed to perform a medically adequate physical examination or determine positive medical indication to do so. There is not an adequate back pain history discussing quality of pain, location, radiation, precipitating physical activity, or mechanism of injury. He prescribed opioid pain medications on the strength of a few statements from the patient concerning past medications, degree of pain, and the fact of his accident, without any corroborating physician examination, laboratory tests, or radiologic work up. There was no substance abuse history taken, despite the fact that M.F. noted continued alcohol and marijuana use.

c. Even though it was obvious that M.F. had been or was being treated for his pain by other practitioners, Respondent failed to obtain releases to consult with or to obtain records from these previous or concurrent treating physicians before continuing to prescribe pain medications.

d. Respondent failed to do a proper lower back pain evaluation and/or refer M.F. to a specialist in the treatment of back pain or pain management.

e. Respondent failed to formulate a treatment plan or goals for M.F.

f. In a patient with a history of continuous marijuana and alcohol use, Respondent failed to order a drug screen for M.F. or check CURES for any evidence of parallel prescribing or previous prescribing.

g. Respondent failed to take an interim history when he resumed M.F.'s care in September 2008 after more than a year. He failed to inquire as to pain experienced, drugs taken, other practitioners consulted, or any drug or alcohol abuse or arrests. Respondent simply resumed prescribing opioid controlled substances.

h. Respondent continued to prescribe controlled substances for M.F. in the period between August 20, 2007 and September 10, 2008 when M.F. had no office visits with Respondent.

i. Respondent failed to carefully monitor the use of opioid pain medications in a patient who admitted to past and present alcohol and marijuana use.

j. Respondent failed to document in any office note any functional benefit or loss from the use of controlled substances for pain that warranted any continued use, modification, change, or discontinuance of these medications.

TWELFTH CAUSE FOR DISCIPLINE

(Prescribing Without Examination/Medical Indication – Patient M.F.

129. The allegations of the Eleventh Cause for Discipline are incorporated herein by reference as if fully set forth.

130. Respondent prescribed controlled substances to M.F. without appropriate examination and medical indication and therefore is subject to discipline under sections 2242(a) and 2234 of the Code in that;

a. Respondent prescribed opioid pain medications to M.F. without a thorough physical examination confirming the fact, nature, and etiology of the pain, without confirming laboratory or radiologic testing, without obtaining records of previous or concurrent physicians, and without taking a drug/alcohol abuse history.

b. Respondent continued to prescribe opioid pain medications to M.F. during a period of more than one year in which he had no office appointments with M.F.

c. Respondent had no treatment plan for M.F. and did not indicate any benefit or detriment from the controlled substances which had been prescribed in M.F.'s patient record.

d. Respondent failed to indicate in M.F.'s patient record any rationale for the amount and kind of controlled substances prescribed or any medical reason for an alteration in dosage, amount, or kind of medication.

THIRTEENTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Records – Patient M.F.)

131. The allegations of the Eleventh Cause for Discipline are incorporated herein by reference as if fully set forth.

132. Respondent kept inaccurate and inadequate medical records for M.F. and therefore is subject to discipline under sections 2266 and 2234 of the Code in that:

a. Respondent's records for M.F. are sketchy, illegible, and inaccurate in that he failed to record or keep a copy of all of his controlled substance prescriptions for M.F. and failed to document a confirmatory physical examination, diagnosis, treatment plan or rationale for the continued prescription of M.F.'s lower back pain.

b. Respondent consistently prescribed opioid pain medications for M.F. without documentation of any confirmatory physical examination, laboratory test, X-ray examination, consultation, or referral.

c. Respondent did not document any treatment plan for M.F. or any follow up examinations indicating the results of any treatment or prescription in alleviating pain or improving quality of life.

FOURTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Negligence/Incompetence – Patient A.B.)

133. Respondent was reportedly retained to treat A.B. by her parents when she was a young child, but Respondent has no office medical records for A.B. prior to May 2007. A.B. filled out a new patient registration form for Respondent on June 29, 2007; she was then 28 years

of age. In an office visit note for August 24, 2007, Respondent noted that on July 12, 2007, A.B. was in a motor vehicle accident and that she was locally tender on the right side of her neck. A pain diagram indicates pain from 3-8/10 and reduced ability to participate in physical activities. A pain assessment form is filled out concluding that A.B. is in intractable pain. Diagnosis is indicated as posterior neck pain and headache. Plan of treatment indicates local heat, stretching, NSAID *prn*, and NAC as needed 30-90 per day.

134. A.B.'s records contain an undated checklist for long term opioid therapy with an indication, but no detailed data, of a complete history and physical examination dated February 7, 2008. This form indicated that there was medical indication for use of a controlled substance and that A.B. was warned of the risks and benefits of such therapy. **CURES records indicate that A.B. filled Respondent's prescriptions for Alprazolam 1 mg. #30 on February 7, 2008, February 15, 2008, and March 10, 2008 and for APAP/hydrocodone 500/5 #100 on February 7, 2008, #60 on February 15, 2008, #100 on March 10, 2008, and #60 on March 27, 2008.**

135. A.B.'s next recorded office visit was on March 31, 2008. Cervical pain and pain in the right shoulder and scalp were noted, along with right temporal headache. Respondent notes Vicodin HP #100 x 1 ½ *q* 6h, naprosyn 375, alprazolam .5 mg, local heat *q*8H, counter irritant, rehab massage 3x month. There is a notation for x-ray in 6 weeks. **CURES records indicate that A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #120 on March 31, 2008 and April 15, 2008, and #150 on April 30 2008; APAP/hydrocodone 500/5 #60 on May 20, 2008; alprazolam .5 mg #30 on March 31, 2008 and April 21, 2008; and alprazolam 1 mg #30 on April 30, 2008 and May 19, 2008.**

136. A.B.'s next office visit was on June 4, 2008. Neck pain was noted as well as an ER visit on May 29, 2008 with no details other than "no x-ray,""MRI scheduled" in Greenbrae, and "missed 4 days work." Vital signs were recorded. Range of motion is noted to be decreased in the neck and shoulder, with the right side of the neck tender. Respondent notes Norco 10/325 5/mx and alprazolam 1 mg *q*12h as well as Advil as treatments. There is a report on an MRI taken on June 6, 2008, which had been ordered by H.K., M.D., which indicates a diagnosis of

thoracic outlet syndrome with scalene entrapment. **CURES records indicate that A.B. filled Respondent's prescription for alprazolam 1 mg. #30 on June 13, 2008.**

137. A.B.'s next office visit was on June 29, 2008. Physical examination form was completed and present illness is noted as a MVA in November of 2007, which is not described. Respondent notes recent neck pain and right shoulder pain radiating down to the right hand. He notes depression secondary to chronic pain. Respondent notes TENS, biofeedback, alprazolam 1 mg. *q*12h, gabapentin 100 mg *bid*, and Norco 10/325 #180 *q*8h as treatments. Vital signs included a heart rate of 100 bpm. Respondent indicates cervical discitis and chronic pain syndrome. **CURES records indicate that A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #180 and alprazolam 1 mg. #60 on June 29, 2008, July 24, 2008, July 28, 2008, August 22, 2008, August 24, 2008, and August 26, 2008, filled at various pharmacies.**

138. On August 29, 2008, Respondent received a facsimile transmittal from H.K., M.D. Dr. K. alerted Respondent that she had ordered a CURES Patient Prescription History for A.B. for May 1, 2008 through August 25, 2008, and that the report, which was included with the fax, indicated that A.B. was receiving prescriptions for APAP/hydrocodone from several different providers, with Respondent being the most frequent provider, and filling the prescriptions at different pharmacies. Respondent did not address with A.B. the issue of receiving narcotic prescriptions from multiple providers and filling them at multiple pharmacies.

139. A.B. next saw Respondent on September 2, 2008. A physical examination form was completed. Heart rate is noted as 100 bpm. Respondent notes the present complaint is neck pain right side, with a past history of MVA's, one in November 2004 and another in November 2007; no mention is made of the July 2007 MVA which initiated Respondent's pain treatment for A.B. It is noted that the neck is locally tender. Pain level is recorded as 7.5/10, with the best being 5/10. Impression is acute cervical discitis and pain cervical spine. Respondent notes Norco 10/325 *q*5/day and Advil 600 mg daily. No discussion of Dr. K's suspected diversion of drugs was noted; no drug abuse history was taken; and no CURES report was ordered. No warning concerning maximum daily intake of acetaminophen was noted. **CURES records indicate that**

A.B. filled Respondent's prescription for APAP/hydrocodone 325/10 #75 on September 4, 2008.

140. A.B. next saw Respondent on September 11, 2008 for periodic neck pain and numbness. Respondent noted the need for a MRI of the cervical spine. Pain was noted as 8/10. Heart rate was noted as 118 bpm. Respondent again noted cervical discitis and neck pain. He noted trazodone 5 mg. HS, gabapentin 200 mg. *q*6h, Norco 10/325 1½ *q*8hr #135, and alprazolam 1 mg *q*12hr #60. **CURES records indicate that A.B. filled Respondent's prescriptions for APAP/hydrocodone #75 on September 23, 2008 and September 24, 2008 and #135 on September 11, 2008; A.B. filled Respondent's prescriptions for alprazolam 2 mg. #60 on September 18, 2008 and September 27, 2008.**

141. A.B. next saw Respondent on October 9, 2008. A patient physical examination form was completed. The 11/04 and 11/07 MVA's are mentioned as well as a third in May 2008. Respondent noted the results of the MRI scan of June 6, 2008. Pain was noted as 9/10. Heart rate was noted as 118 bpm. Respondent noted Norco 10/325 #140, alprazolam 1 mg.(illegible), and gabapentin 600 mg. #100 ½ *bid.* **CURES records indicated that A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #140 on October 9, 2008 and November 1, 2008 and #135 on October 20, 2008; A.B. filled Respondent's prescription for alprazolam 1 mg. #60 on October 11, 2008.**

142. On October 25, 2008, Respondent received a profile on A.B. from one Longs Drugs in Santa Rosa, where the pharmacist indicates that A.B. received 420 hydrocodone/APAP 5/325 and 10/325 in August 2008, 360 hydrocodone/APAP 10/325 in September 2008, and 275 hydrocodone/APAP 10/325 in October 2008. A.B. had submitted a request for refill of the previous prescription filled at this particular pharmacy on October 20, 2008. Respondent rejected the request for refill but continued to prescribe hydrocodone/APAP in large amounts to A.B.

143. A.B. next saw Respondent on November 16, 2008. A patient physical form was completed. Notes indicate four MVA's in May 2004, May 2008, November 2007, and October 2008, with notes indicating the last MVA was caused by a drunk driver. Heart rate was noted as 122 bpm. Respondent noted a tender upper neck, with impression being sinus ventricular

tachycardia secondary to anxiety, white coat syndrome and, right cervical spine radiculopathy. Respondent noted Advil, Toprol XL 5 *qTHS* for palpitations, alprazolam 1 mg *bid*, Norco 2 mg o*q*8hr, gabapentin 300 mg. *q*8h, and Soma. Respondent did not obtain an EKG or examine A.B. for causes of her tachycardia, including tests for anemia, thyroid problems, or stimulant abuse. Respondent did not refer A.B. to a cardiologist for assessment of her tachycardia. **CURES records indicate that A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #140 and alprazolam 1 mg #120 on December 1, 2008.**

144. On December 8, 2008, Respondent received a profile on A.B. from the same Longs Drugs in Santa Rosa which indicated that A.B. had requested a refill of Respondent's prescription for APAP/hydrocodone which she had last filled on December 1, 2008. The profile indicates that A.B. received 360 hydrocodone/APAP in November 2008 and the prescription filled on December 1, 2008 was for 140 tablets. Respondent rejected this refill request, but authorized a refill for December 24, 2008.

145. A.B. next saw Respondent on December 11, 2008. A patient physical examination form was completed. Present illness was not listed. Past history of neck pain, headaches, and anxiety was listed. There is a note to have A.B. see a psychologist. Heart rate was 106 bpm. Respondent noted alprazolam 1 mg. 1 *q*8hr. **CURES records indicate that A.B. filled Respondent's prescription for alprazolam 1 mg #60 on December 24, 2008.**

146. A.B. next saw Respondent on January 20, 2009. A patient physical examination form was completed. Present illness was listed as neck pain, with pain listed as 8/10. Respondent notes that A.B. is seeing a psychologist three times a week. Heart rate is listed as 132 bpm. Neck is described as locally tender with range of motion decreased. Impressions included supraventricular tachycardia caused by anxiety and cervical spine neuropathy. Respondent lists medications as Toprol XL 25, Norco 10/325 A#180, gabapentin 400 *tid*, Flexeril 5 mg, alprazolam 1 mg 5x/day, 1 *q* bed. **Pharmacy records in A.B.'s chart indicate A.B. filled Respondent's prescriptions for hydrocodone/APAP 10/325 A#180 on February 2, 2009, and February 28, 2009; alprazolam 1 mg #100 on February 2, 2009 and March 3, 2009; and tramadol 50 mg. #90 with 1 refill on February 2, 2009.**

147. A.B. next saw Respondent on April 6, 2009. At this visit, Respondent had A.B. sign a Long Term Controlled Substances for Chronic Pain Sample Agreement, and in it, A.B. agrees to receive controlled substances prescriptions only from Respondent, to fill those prescriptions only at one pharmacy, Longs Drugs in Petaluma, to inform Respondent of any new medications, access to all other physicians A.B. has consulted, to submit to unannounced urine or serum drug screens, to know that lost, stolen, or damaged medications will not be replaced, to know that early refills will not be given, and to understand that failure to comply with the agreement will result in Respondent's ceasing to prescribe controlled substances for A.B. A.B. also signed a Consent for Chronic Opioid Therapy. A patient physical examination form was completed with the present illness listed as neck pain, now 7/10. Heart rate is listed as 100 bpm. Neck is listed as locally tender with decreased range of motion secondary to pain. Impression includes odontoid process malposition, headaches, chronic pain, and depression. Notations indicate massage 2x/month, local heat, Norco 10/325 180 x 2, tramadol 5 mg 90 x 2, and smoke ½ ppd.

148. **CURES records indicate that A.B. filled no prescriptions from Respondent for controlled substances between February 2, 2009 and June 6, 2009. At CVS Pharmacy #xxx80, A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #180 June 6, 2009, July 6, 2009, and August 10, 2009; #100 on December 21, 2009 and December 21, 2009; #90 on September 10, 2009 and September 29, 2009, and #30 on July 21, 2009 and August 3, 2009. At CVS Pharmacy #xxx46, A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #135 on June 22, 2009, August 16, 2009, September 8, 2009, October 8, 2009, and December 5, 2009; #60 on June 17, 2009, September 8, 2009, September 11, 2009, October 8, 2009, November 8, 2009, and December 10, 2009; #30 on June 8, 2009, June 18, 2009, July 8, 2009, July 26, 2009, August 28, 2009, and November 30, 2009; #20 on June 8, 2009, July 8, 2009, and August 9, 2009. The number of APAP/hydrocodone pills indicated would indicate that A.B. ingested an average of approximately 11 grams of acetaminophen and 350 mg. of hydrocodone per day between June 6, 2009 and the end of December 2009. Respondent's chart for A.B. indicates a great number of refill requests for APAP/hydrocodone, some of which were refused, but most of**

which were approved with the refill amount sometimes limited. These requests came from two CVS (Longs) pharmacies and occasionally Walgreen's.

149. **At CVS Pharmacy #xxx46, A.B. filled Respondent's prescriptions for alprazolam 1 mg. #60 on June 17, 2009, September 8, 2009, September 11, 2009, October 8, 2009, November 8, 2009, and December 10, 2009; #30 on June 8, 2009, August 28, 2009, and November 30, 2009; and #20 on June 8, 2009, July 8, 2009, and August 9, 2009. Records do not indicate that A.B. filled any prescriptions for alprazolam at CVS Pharmacy #xxx80.**

150. In Respondent's chart for A.B. is a communication dated June 29, 2009 from Longs Drugs Store (now CVS) #xxx80 indicating to Respondent that A.B. is filling prescriptions both at this location and at another Longs (CVS) Drug Store in Petaluma. This communication was after A.B. signed her agreement for long term treatment for chronic pain in April 2009. Respondent for the first time ordered a Patient Activity Request from CURES on July 21, 2009, but otherwise did not act upon the information received from Longs (CVS) Drug Store on June 29, 2009.

151. In Respondent's chart for A.B. is a letter from A.B. dated August 19, 2009 wherein A.B. reminds Respondent that she is a long time patient and indicates that she is suffering anxiety, depression and neck pain radiating to her right hand. She indicated she has developed a fear of leaving her home and wants to try antidepressants. There is another letter from A.B. dated September 29, 2009 wherein A.B. asks for help obtaining disability benefits and indicates the onset of her disability as November 25, 2008 and that it includes anxiety, depression, and neck pain. She requested disability benefits through at least December 25, 2009. There is no indication that Respondent followed up on these requests.

152. A.B.'s next appointment with Respondent was on January 11, 2010, nine (9) months after the previous appointment. A patient physical examination form was completed. Present illness was listed as MVA with malalignment at C1-C2 and HNP C6-7. There is an indication of Toprol XL 50 mg daily and an illegible entry apparently concerning pain medications. Present history is listed as radiating neck pain right side and depression. Heart rate is listed as 116 bpm. Neck is described as locally tender with decreased range of motion. Impression is acute cervical pain; C1-C2 malalignment; HNP C6-C7; chronic pain. **CURES records indicate that A.B.**

filled Respondent's prescriptions for APAP/hydrocodone 325/10 #100 on January 11, 2010, January 21, 2010, February 2, 2010, and March 16, 2010; #120 on February 25, 2010; and #135 on March 2, 2010. A.B. filled Respondent's prescriptions for alprazolam 1 mg #60 on January 11, 2010, January 27, 2010, February 12, 2010, and March 12, 2010.

153. A.B.'s next appointment with Respondent was on March 24, 2010. A patient examination form was completed. Present illness is listed as MVA right side neck pain radiating to right hand. Past history is listed as HNP C6C7; C1C2 malalignment. Pain is listed as 7.5/10. Notations indicate Local heat help; Advil 2 *bid* PC 5/7 per day; Norco 10/325 1*q*6h #120; Soma 350 1/2 hs; alprazolam 2 mg 1/2 *q*8h; Cymbalta 60 mg. The name of A.B.'s psychologist is mentioned. The neck is described as tender up to occiput. Impression is anxious with cervical pain. **CURES records indicate that A.B. filled Respondent's prescriptions for APAP/hydrocodone 325/10 #120 on March 24, 2010 and April 3, 2010 and #100 on April 8, 2010 and April 20, 2010. AB filled Respondent's prescription for alprazolam l mg #90 on April 1, 2010.**

154. Respondent for the first time ordered a urine drug screen for alprazolam, Norco, Soma, and tramadol at the March 24, 2010 appointment. The specimen was collected on March 24, 2010 and results were reported on April 5, 2010. Although Respondent had consistently prescribed alprazolam for A.B., the drug screen was negative for benzodiazepines. There is no indication in the record that Respondent addressed this inconsistency with A.B. Respondent continued to prescribe alprazolam for A.B.

155. A.B.'s next appointment with Respondent was on June 23, 2010. A patient physical examination form was completed. Present illness is listed as MVA; right side neck pain radiating to right hand. Past history indicates HNP C6-7; C1-2 malalignment. Pain was listed as 7.5/10. The name of A.B.'s psychologist is mentioned. The neck is described as tender from the cervical spine to the occiput. Impressions were anxiety and cervical pain. No mention is made of the urine test results. Respondent notes Local heat help; Advil 2 *bid* PC 5/7 day; Norco 10/325 1*q*6h #120; Soma 350 1/2 hs; and alprazolam 2 mg. 1/2*q*8h. **CURES reports were not obtained for prescriptions filled after April 20, 2010, but Respondent's records indicate prescriptions**

filled for hydrocodone/APAP 10/325 on May 1, 2010 #120 (refill), May 2, 2010 #120, May 30, 2010 #100 (refill), May 31, 2010 #100, June 23, 2010 #100, July 23, 2010 #100 (refill), August 23, 2010 #100 (refill), August 25, 2010 #100, September 26, 2010 #100 (refill), September 27, 2010 #120, and October 12, 2010 #100 (refill). For alprazolam, Respondent's records indicate prescriptions filled for May 3, 2010 #75(refill), May 20, 2010 #60, June 23, 2010 #60 (refill), June 23, 2010 #60, July 19, 2010 #60, August 19, 2010 #60 (refill), and September 27, 2010 #60 (refill).

156. A.B.'s last visit with Respondent in available records was November 7, 2010. Respondent used a new office visit form. Treatment objectives were not entered. Present illness was MVA and bronchitis. Past history was listed as multiple DDD with HNP. Pain was listed as 7/10. Medications were listed as Keflex 500 mg *tid*, Norco 10 *qid*, alprazolam 2 mg #45 1/2 *q*8h. The neck was described as stiff. Diagnosis was acute bronchitis. **CURES reports were not obtained for prescriptions filled after April 20, 2010, but Respondent's records indicate prescriptions for hydrocodone/APAP 10/325 were filled on November 22, 2010, December 6, 2010 #120 (refill), January 7, 2011 #116 (refill), January 18, 2011 #110 (refill), and February 7, 2011 #112 (refill). For alprazolam, Respondent's records indicate a prescription filled on December 15, 2010 #60 and on January 14, 2011 #56 (refill).**

157. On December 2, 2010, Respondent obtained a CURES PAR for A.B. from June 2, 2010 through December 2, 2010 which indicated that A.B. filled his prescriptions for great amounts of APAP/hydrocodone and alprazolam in that time period. Respondent's only comment on the sheets was "not multiple MD's." Dr. H.K.'s message to Respondent indicating that A.B. was receiving prescriptions for controlled substances from multiple providers was received in August of 2008. Respondent does not note consideration of the amounts of controlled substances A.B. obtained, whether any significant improvement had been made despite the treatment, or the fact that A.B.'s March 2010 urine screen had tested negative for benzodiazepines.

158. Respondent is subject to discipline under sections 2234(b) and/or (c) and/or (d) of the Code in that he is guilty of gross negligence and/or negligence and/or incompetence in his care and treatment of patient A.B. by reason of the following acts or omissions:

a. Despite the fact that he had provided care for A.B. for injuries sustained in apparently three separate motor vehicle accidents for over four (4) years, Respondent did not document a complete workup or physical examination. There was no complete history and physical, no detailed psychological assessment, no detailed orthopedic or neurological history and physical. He did not do a full assessment of pain or an assessment of physical and psychological functioning. He did not take a substance abuse history, a history of prior pain treatment, or do an assessment, including diagnostic tests, of underlying or coexisting diseases or conditions. He did not document a recognized medical indication for long term use of controlled substances.

b. Respondent failed to refer A.B. to a pain management physician and/or a spine specialist for the definitive treatment of her cervical pain and radicular complaints. He demonstrated a lack of knowledge of appropriate treatment options for spinal pathology.

c. Respondent did not consider medication misuse or diversion in A.B.'s increasing need for controlled substances or refer A.B. to an addiction/pain management specialist for assessment of this condition.

d. Respondent did not develop a treatment plan for A.B. or set forth clear objectives for treatment by which the treatment plan can be evaluated.

e. Respondent failed to obtain a release of information authorization from A.B. from her previous or contemporaneous treating physicians, contact her previous physicians, or search the CURES program for information related to previous controlled substance prescriptions or evidence of diversion. When he was notified of possible drug diversion by another treating physician or informed by pharmacies that prescriptions were being filled at different pharmacies in close temporal proximity, Respondent failed to respond to these warnings and failed to discuss this information with the patient or alter his treatment or prescribing accordingly.

f. Respondent failed to consider non-narcotic treatments for A.B.'s cervical pain such as physical therapy, biofeedback, or injection therapy before prescribing controlled substances. Opiates are not a first line treatment for chronic intractable pain.

g. Respondent failed to consider or warn A.B. about the dangers of long term use of more than four (4) grams per day of acetaminophen, and in many instances, A.B.'s acetaminophen prescribed intake per day exceeded the maximum safe recommended dosage.

h. Respondent failed to properly evaluate and treat A.B.'s tachycardia. He did not obtain an EKG to determine the type of tachycardia or consider potential causes for tachycardia such as use of stimulants, drug withdrawal, anemia, hyperthyroidism, or pulmonary conditions. He failed to refer A.B. to a cardiologist for definitive diagnosis and treatment.

i. In noting A.B.'s constant depression and anxiety which was at times debilitating, Respondent failed to refer A.B. to a psychiatrist for treatment. He noted that A.B. was seeing a psychologist, but sought no consultation. Even when A.B. asked to be placed on antidepressants, respondent did not consider that a psychiatric referral or at least a consultation was necessary.

j. Respondent did not have A.B. sign a contract for pain treatment until April of 2009, years after he had begun treatment with controlled substances, and even after the agreement was signed, he took no steps to stop or curtail or alter his treatment when A.B. clearly violated the agreement.

FIFTEENTH CAUSE FOR DISCIPLINE

(Prescribing Without Examination/Medical Indication - Patient A.B.)

159. The allegations of the Fourteenth Cause for Discipline are incorporated herein by reference as if fully set forth.

160. Respondent prescribed controlled substances to A.B. without appropriate examination and medical indication and therefore is subject to discipline under sections 2242(a) and 2234 of the Code in that:

a. Respondent prescribed opioid pain medication for A.B. without a thorough physical examination confirming the fact, nature, and etiology of the pain, without confirming laboratory or radiologic testing, without obtaining records or consultation from previous or concurrent treating physicians, and without taking a detailed drug/alcohol abuse history.

b. Respondent continued to prescribe large amounts of opioid pain medications and benzodiazepines to A.B. during long periods in which she had no office visits with him.

c. Respondent had no treatment plan for A.B. and did not indicate any detriment/benefit from the controlled substances which he had prescribed at each visit.

d. Respondent failed to indicate in A.B.'s patient record any rationale for the amount and kind of controlled substances prescribed or any medical reason for an alteration in dosage or amount of medication.

SIXTEENTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Records – Patient A.B.)

161. The allegations of the Fourteenth Cause for Discipline are incorporated herein by reference as if fully set forth.

162. Respondent kept inaccurate and inadequate medical records for A.B. and therefore is subject to discipline under sections 2266 and 2234 of the Code in that:

a. Respondent's office notes fail to adequately describe any lack of aberrant behavior, lack of side effects, or the efficacy of the drug treatments which would warrant ongoing treatment or alterations in dosage or amount of medications prescribed.

b. Respondent's records for A.B. are sketchy, disorganized, illegible and inaccurate. He failed to record all prescriptions for controlled substances and keep track of all refills authorized and not authorized.

c. Respondent failed to document a detailed confirmatory physical examination supporting his diagnoses, failed to document a treatment plan, the efficacy of that treatment plan, or any rationale for the continued treatment of A.B.'s cervical pain with large amounts of narcotic pain medication containing acetaminophen.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence – All Patients).

163. The allegations of the First (H.A), Fourth (M.B.), Seventh (M.H.), Eighth (J.B.), Eleventh (M.F.), and Fourteenth (A.B.) Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

164. Respondent's acts or omissions in his treatment of patients H.A., M.B., M.H., J.B., M.F., and A.B., whether jointly or in any combination thereof, constitute repeated acts of negligence and therefore cause for discipline exists under section 2234(c) of the Code.

DISCIPLINE CONSIDERATIONS

165. To determine the degree of discipline, if any, to be imposed upon Respondent, Complainant alleges that on or about November 20, 1991, an accusation was filed against Respondent before the Board in Case No. 03-1990-620. Accusation No. 03-1990-620 alleging violations of sections 2236 and 2237 of the Code (conviction of four counts of violating Health and Safety Code section 11153(a), issuing prescriptions without a legitimate medical purpose); section 2242 of the Code (prescribing dangerous drugs without a good faith prior examination or medical indication); section 725 of the Code (excessive prescribing); and section 2234(e) of the Code (unprofessional conduct – soliciting sexual favors from a patient).

166. On or about February 15, 1995, a Supplemental Accusation was filed in Case No. D-4646, alleging the following violations:

a. With respect to five (5) patients allegedly injured in a minor rear-end car accident in November 1991, all of whom had made insurance claims and all of whom had been referred to Respondent by the same attorney: As to each of the five passengers/patients, violations of section 2234(b) and (c) of the Code (gross negligence/repeated negligence in that diagnoses were not supported by medical records or x-rays, indication for physical therapy referral inadequate, referral to unlicensed physical therapist, and failure to check on progress in physical therapy); sections 810 and 2234(e) of the Code (Insurance Fraud); and section 725 of the Code (excessive prescribing of treatment).

b. With respect to one patient, violations of section 2234(c) of the Code (inappropriately prescribing prescription lenses, hypertension medication, and weight reduction medication without appropriate examination/medical indication/adequate instructions); sections 810 and 2234(e) of the Code (Insurance [Workers Compensation Disability Claim] Fraud); section 2261 of the Code (making or signing a document related to medicine which falsely represents a state of

facts); and section 125 of the Code (conspiracy with patient to defraud Workers Compensation Appeals Board).

c. With respect to eight (8) patients at a convalescent home in Novato: Violations of section 725 of the Code (excessively and unnecessarily prescribing numerous x-rays and other diagnostic tests).

d. With respect to a corporation which provided x-rays to patients and healthcare facilities in which respondent was an owner and shareholder: Violations of 2234(b) of the Code (gross negligence in causing or allowing the corporation to employ unlicensed persons as radiological technicians to take x-rays).

e. With respect to Respondent's representation on his letterhead, business cards, and advertisements that he was Board-Certified by the American Board of Family Practice, when his certification lapsed in 1981 and was not renewed: Violations of section 2234 of the Code (general unprofessional conduct) and 2261 of the Code (making or signing a document related to medicine which falsely represents a state of facts).

167. In or about November 1995, Respondent entered into a stipulation in Case No. 03-1990-620 and the stipulation was adopted by the Board as its Decision in the matter, effective February 23, 1996. Respondent's Physician and Surgeon's Certificate was revoked, with the revocation stayed, and respondent was placed on five (5) years probation on terms and conditions including an ethics course, physician monitor, controlled substance prescribing restrictions, maintenance of drug logs, and restitution to the insurance company paying for treatments of the five (5) patients allegedly injured in the November 1991 auto accident. That decision is now final and is incorporated by reference as if fully set forth.

168. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about April 12, 1999, an Accusation was filed in Case No. 03-98-83504 before the Board. This Accusation charged Respondent with violations of section 2234(b), (c) and/or (d) of the Code with respect to his care and treatment of seven (7) elderly or older patients at Novato Community Hospital (gross negligence/negligence/incompetence) On May 7, 2001, effective immediately, the Board adopted a stipulation between the parties as its

Decision in the matter, which provided for an extension of Respondent's probation to December 31, 2001 with additional terms and conditions including an oral clinical examination, education course, and physician practice monitor. That decision is now final and is incorporated by reference as if fully set forth.

169. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about December 24, 2001, a Petition to Revoke Probation was filed against Respondent in Case No. 03-1990-620/D1-1990-620; 03-1998-83504/D1-1998-83504 and on June 6, 2002, an Amended Petition to Revoke Probation was filed. The Amended Petition alleged that Respondent had failed to document numerous prescriptions for controlled substances for one patient in his drug log and failed to document recommendations for marijuana to another patient. On April 17, 2003, the Board adopted as its Decision in the case a Stipulated Decision and Disciplinary Order which extended Respondent's probationary period until January 1, 2004 and imposed further terms and conditions including a prescribing practices course, a medical record keeping course, maintenance of a record of all controlled substances prescribed, dispensed or administered, and psychotherapy. The Decision was effective May 19, 2003. That decision is now final and is incorporated by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician and Surgeon's Certificate No. G 20523, issued to Ray Poon-Phang Seet, M.D.;

2. Revoking, suspending or denying approval of Ray Poon-Phang Seet, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering Ray Poon-Phang Seet, M.D. to pay the Medical Board of California the costs of probation monitoring;

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

DATED: February 8, 2012

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

SF201020032
20264112.doc