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

In the Matter of the Accusation Against:	)	
COLLIN LEONG, M.D.	)	**Case No. 03-2012-220574**
Physician's and Surgeon's Certificate No. A-23867	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 4, 2014

IT IS SO ORDERED January 28, 2014 .

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Interim Executive Director

PLAINTIFF TRIAL EXHIBIT
P-27610_00001

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **COLLIN LEONG, M.D.** 929 Clay Street, Suite 301 San Francisco, CA 94108 Physician's and Surgeon's Certificate No. A23867 Respondent.	Case No. 03-2012-220574 OAH No. 2013100552 **STIPULATION FOR SURRENDER OF CERTIFICATE**

In the interest of a prompt and speedy resolution of this matter, consistent with the public interest and the responsibility of the Medical Board of California, Department of Consumer Affairs, (hereinafter, the "Board"), the parties hereby agree to the following Stipulation for Surrender of Certificate which will be submitted to the Board for its approval and adoption as the final disposition of Case No. 03-2012-220574.

1. Kimberly Kirchmeyer ("Complainant") is the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs, who brought this action solely in her official capacity. She is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Lawrence Mercer, Deputy Attorney General.

2. Collin Leong, M.D., (Respondent) is represented in this matter by his attorneys Michael F. Wohlstadter and Mark Mandel, 488-7th Street, Oakland, CA 94607.

3. On July 20, 1970, the Medical Board (Board) issued Physician's and Surgeon's Certificate A23867 to Collin Leong, M.D. (Respondent.) The certificate is renewed and current with an expiration date of February 28, 2015.

JURISDICTION

4. Accusation No. 03-2012-220574 ("Accusation") was filed before the board and is currently pending against Respondent. The Accusation, together with all other statutorily required documents, was duly served on Respondent at his address of record. A copy of Accusation No. 03-2012-220574 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read and understands the charges and allegations in Accusation No. 03-2012-220574. Respondent has also carefully read and understands the effects of this Stipulation for Surrender of Certificate.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

ACKNOWLEDGMENTS

8. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with regard to the charges in the Accusation. Respondent hereby gives up his right to contest these charges and he agrees that his Physician's and Surgeon's

Certificate is subject to discipline pursuant to section 2234(b) of the Business and Professions Code.

9. Respondent desires and agrees to surrender his Physician's and Surgeon's Certificate for the Board's formal acceptance, thereby giving up his right to practice medicine in the State of California.

RESERVATION

10. The admissions made by Respondent herein are only for the purposes of this proceeding or any other proceedings in which the Medical Board of California or other professional licensing agency in any state is involved, and shall not be admissible in any other criminal or civil proceedings.

CONTINGENCY

11. This Stipulation shall be subject to the approval of the Board. Respondent understands and agrees that Board staff and counsel for Complainant may communicate directly with the Board regarding this Stipulation, without notice to or participation by Respondent or his attorney. If the Board fails to adopt this Stipulation as its Order in this matter, the Stipulation shall be of no force or effect; it shall be inadmissible in any legal action between the parties; and the Board shall not be disqualified from further action in this matter by virtue of its consideration of this Stipulation.

STIPULATION AND ORDER

IT IS THEREFORE STIPULATED AND ORDERED as follows:

1. **SURRENDER** Respondent hereby agrees that he will surrender his wall and wallet Physician's and Surgeon's Certificates and all other indicia of his right to practice medicine in the State of California to the Board or its representative on or before the effective date of this decision, and the Board agrees to accept this surrender in resolution of this matter.

2. **REINSTATEMENT** Respondent fully understands and agrees that if he ever files an application for re-licensure or reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time any petition is filed, and he

understands and agrees that all of the allegations and causes for discipline contained in Accusation No. 03-2012-220574 will be deemed to be true, correct and admitted by him for purposes of the Board's determination whether to grant or deny the petition. Respondent agrees that he will not petition for reinstatement for at least three (3) years following the effective date of this decision. Respondent hereby waives any time-based defense he might otherwise have to the charges contained in Accusation No. 03-2012-220574 including, but not limited to, the equitable defense of laches.

3. Respondent understands that by signing this Stipulation, he is enabling the Board to issue its order accepting the surrender of his license without further process. He further understands that upon acceptance of this Stipulation by the Board, he will no longer be permitted to practice as a physician and surgeon in California.

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ACCEPTANCE

I, COLLIN LEONG, M.D., have carefully read the above Stipulation for Surrender of Certificate, have fully discussed it with my attorneys, and enter into it freely and voluntarily and with full knowledge of its force and effect, do hereby agree to surrender my Physician's and Surgeon's Certificate no. A23867 to the Medical Board of California for its formal acceptance. By signing this Stipulation to surrender my license, I recognize that as of the effective date of its formal acceptance by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California and, if I have not already done so, I also will cause to be delivered to the Board both my license and wallet certificates on or before the effective date of the decision.

Dated: Jan 15-2014

Collin Leong, M.D.
COLLIN LEONG, M.D.
Respondent

I have read and fully discussed with Respondent COLLIN LEONG, M.D. the terms and conditions and other matters contained in the above Stipulation for Surrender of Certificate. I approve its form and content.

Dated: 1-15-14

MICHAEL F. WOHLSTADTER, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulation for Surrender of Certificate is respectfully submitted for consideration by the Medical Board of California, Department of Consumer Affairs.

Dated: 1/23/2014

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

KAMALA D. HARRIS
Attorney General of California
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 16 2013
BY: ANALYST

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

In the Matter of the Accusation Against: **COLLIN LEONG, M.D.** 929 Clay Street, Suite 301 San Francisco, CA 94108 Physician's and Surgeon's Certificate No. A23867 Respondent.	Case No. 03-2012-220574 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On July 20, 1970, the Medical Board (Board) issued Physician's and Surgeon's Certificate A23867 to Collin Leong, M.D. (Respondent.) The certificate is renewed and current with an expiration date of February 28, 2015.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California[1], under the authority of the following laws. All references are to the Business and Professions Code unless otherwise specified.

A. Section 2227 of the Business and Professions Code authorizes the Board to take action against a licensee by revoking, suspending for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action taken as the Board deems proper.

B. Section 2234 of the Code states, in pertinent part, that the Board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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

(b) Gross negligence

(c) Repeated negligent acts

(d) Incompetence

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

C. Section 725 of the code provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensee is unprofessional conduct.

D. Section 2242(a) provides that prescribing, dispensing or furnishing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

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[1]The term "Board" means the Medical Board of California; "Division of Medical Quality" or "Division" shall also be deemed to refer to the Board.

E. Section 2266 of the Code provides that the failure to maintain adequate and accurate records relating to the provision of services to patients constitutes unprofessional conduct.

F. Section 2262 of the Code provides that the altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

4. Respondent is Board Certified in Internal Medicine. At the time of the events alleged in this Accusation, Respondent was engaged in the practice of medicine in San Francisco, California.

FIRST CAUSE FOR DISCIPLINE

Patient YMB

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

5. Respondent saw 22 year old Patient YMB on seven occasions between August 4, 2011 and February 29, 2012. YMB paid cash for each of his visits. Respondent's largely illegible medical record for YMB reflects no physical examination. No vital signs are recorded on any visits, except that on one visit, a weight was taken. The medical history obtained is limited to a notation that YMB had "severe pain" due to a prior gunshot wound or back injury, a "history of bronchitis," and on one visit, a reference is made to an automobile accident. Respondent made no assessment or evaluation of YMB's pain complaints. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse was taken or documented. Respondent's diagnosis for YMB over the course of his treatment was chronic complex pain syndrome and bronchitis.

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6. Over the course of his treatment of YMB, Respondent consistently prescribed large quantities of oxycodone[2] and Soma[3]. On some visits, Valium[4] was prescribed. Respondent's chart contains no documented reason for the Soma and Valium; however, during his Medical Board interview Respondent stated they were prescribed for muscle spasms. Respondent also issued multiple prescriptions for promethazine with codeine cough syrup.[5]

7. At no time during his treatment of YMB did Respondent take steps to objectify the patient's complaints of pain, and he failed to obtain lab studies, toxicology screening, urinalysis, or YMB's past medical records. Respondent failed to adequately consider or evaluate the source of YMB's reported pain.

8. Respondent's medical record for YMB fails to document physical examination or findings, and contains insufficient physical findings to support his clinical diagnosis. His chart fails to adequately document the basis for his prescription of large doses of opiate and sedative medications, or to assess whether YMB demonstrated drug-seeking or aberrant drug behavior.

9. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

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[2] Oxycodone hydrochloride (Oxycontin, Oxycodone IR) is an opioid analgesic. It is a Schedule II controlled substance and narcotic and is a dangerous drug as defined in Business and Professions Code section 4022. Oxycodone can produce drug dependence and, therefore, has the potential for being abused. Oxycontin is indicated for the management of moderate to severe pain, and is a commonly abused or diverted drug, and is known to have a high "street value."

[3] Soma is a trade name for carisoprodol, a muscle relaxant and sedative. Carisoprodol is a dangerous drug as defined by Business and Professions Code section 4022.

[4] Valium is a trade name for diazepam, a psychotropic drug 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. Diazepam 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.

[5] Promethazine cough syrup with codeine is a dangerous drug as defined in section 4022, and a Schedule V controlled substance.

A. Respondent undertook to treat Patient YMB for severe chronic pain, prescribing high doses of narcotic and sedative medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent diagnosed and treated YMB for bronchitis without an adequate history, physical or clinical evidence to support the diagnosis.

C. Respondent prescribed potentially dangerous or even lethal combinations of narcotic and sedative medications without adequate indication or monitoring, and in the absence of a treatment plan with objectives.

D. Respondent failed to thoroughly or adequately evaluate or assess the cause of YMB's complaints of pain.

E. Respondent made no effort to exclude drug diversion or abuse by YMB, and took no history pertaining to drug or alcohol use.

F. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for YMB.

10. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2266 of the Code in that he failed to keep adequate and accurate records for patient YMB:

A. Respondent's medical records fails to adequately document a patient history, medical examination, evaluation, assessment, treatment plan, objectives, informed consent, or rationale for the medications prescribed. The records that were created are largely illegible, and are devoid of information setting forth Respondent's decision making process for his treatment of YMB.

B. Respondent's record fails to adequately document a medical basis or indication for the ongoing prescription of large quantities of opioid narcotics and sedatives, or to document physical examination findings that supported his clinical diagnosis of chronic complex pain syndrome and bronchitis.

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11. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed high dose opioid and sedative medications for patient YMB, in the absence of an appropriate prior medical examination and a medical indication.

SECOND CAUSE FOR DISCIPLINE

Patient DB

(Unprofessional Conduct/Gross Negligence/Negligence/Excessive Prescribing/Inadequate Records)

12. Respondent saw 20 year old Patient DB, who is the brother of Patient YMB, on five occasions between August 4, 2011 and February 14, 2012. DB paid cash for each of his visits. Respondent's largely illegible medical record for DB reflects no physical examination, and no vital signs were taken or recorded. Respondent noted "pain," apparently from a gunshot wound, but there is no physical examination or description of the wound. Other than reference to the gunshot wound, no medical history was obtained. Respondent made no assessment or evaluation of DB's pain complaints. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse was taken or documented. Respondent's diagnosis for DB over the course of his treatment was chronic complex pain syndrome, gunshot wound and bronchitis.

13. Over the course of his treatment of DB, Respondent prescribed Vicodin, Norco[6] oxycodone, Soma, Valium, and promethazine with codeine cough syrup. Respondent's chart fails to document any rationale for the prescriptions. Respondent stated during his Medical Board interview that he prescribed the drugs requested by DB.

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[6] Vicodin and Norco are trade names for a combination of hydrocodone bitartrate and acetaminophen, a semisynthetic narcotic (opioid) analgesic. They are a Schedule III controlled substance and narcotic and a dangerous drug as defined in Business and Professions Code section 4022. They are indicated for the relief of moderate to moderately severe pain. Tolerance to hydrocodone can develop with continued use.

14. At no time during his treatment of DB did Respondent take steps to objectify his complaints of pain, and Respondent failed to obtain lab studies, toxicology screening, urinalysis or DB's past medical records. Respondent failed to adequately consider or evaluate the source of DB's reported pain.

15. Respondent's medical record for DB fails to document physical examination or findings. His record contains insufficient physical findings to support his clinical diagnosis. His chart fails to adequately document the basis for his prescription of large doses of opiate and sedative medications, or to assess whether DB demonstrated drug-seeking or aberrant drug behavior.

16. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent undertook to treat Patient DB for severe chronic pain, prescribing high doses of narcotic and sedative medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent diagnosed and treated DB for bronchitis without an adequate history, physical or clinical evidence to support the diagnosis.

C. Respondent prescribed potentially dangerous or even lethal combinations of narcotic and sedative medications without adequate indication or monitoring, and in the absence of a treatment plan with objectives.

D. Respondent failed to thoroughly or adequately evaluate or assess the cause of DB's complaints of pain.

E. Respondent made no effort to exclude drug diversion or abuse by DB, and took no history pertaining to drug or alcohol use.

F. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for DB.

17. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2266 of the Code in that he failed to keep adequate and accurate records for patient DB:

A. Respondent's medical records fails to adequately document a patient history, medical examination, evaluation, assessment, treatment plan, objectives, informed consent, or rationale for the medications prescribed. The records that were created are largely illegible, and are devoid of information setting forth Respondent's decision making process for his treatment of DB.

B. Respondent's record fails to adequately document a medical basis or indication for the ongoing prescription of large quantities of opioid narcotics and sedatives, or to document physical examination findings that supported his clinical diagnosis of chronic complex pain syndrome and bronchitis.

18. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed high dose opioid and sedative medications for patient DB, in the absence of an appropriate prior medical examination and a medical indication, and without taking steps to monitor the patient.

THIRD CAUSE FOR DISCIPLINE

Patient RB

(Unprofessional Conduct/Gross Negligence/Negligence/Excessive Prescribing/Inadequate Records)

19. Respondent saw 52 year old Patient RB, who is the father of Patients YMB and DB, on 10 occasions between June 29, 2011 and May 23, 2012. Respondent's largely illegible medical record for RB reflects extremely minimal physical examination: a blood pressure and negative physical exam are noted for the first and last visits. Minimal medical history was obtained, and what was noted was not followed up upon. Respondent made no assessment or evaluation of RB's pain complaints. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse

was taken or documented. Respondent's diagnosis for RB was bronchitis, osteoarthritis and hypertension. Respondent conducted no evaluation or workup of any of these conditions.

20. Over the course of his treatment of RB, Respondent prescribed hydrocodone, oxycodone, Valium, Soma and promethazine with codeine cough syrup. Respondent's chart fails to document any rationale for the prescriptions. Respondent stated during his Medical Board interview that he prescribed the drugs requested by RB.

21. At no time during his treatment of RB did Respondent take steps to objectify his complaints of pain, and he failed to obtain lab studies, toxicology screening, or urinalysis. He never obtained RB's past medical records. Respondent failed to adequately consider or evaluate the source of RB's reported pain. He failed to work up or evaluate his diagnosis of hypertension or bronchitis.

22. Respondent's medical record for RB fails to document an adequate physical examination or findings. His record contains insufficient physical findings to support his clinical diagnosis. His chart fails to adequately document the basis for his prescription of opiate and sedative medications, or to assess whether RB demonstrated drug-seeking or aberrant drug behavior.

23. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent undertook to treat Patient RB for chronic pain, prescribing high doses of narcotic and sedative medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent diagnosed and treated RB for bronchitis without an adequate history, physical or clinical evidence to support the diagnosis.

C. Respondent prescribed potentially dangerous or even lethal combinations of narcotic and sedative medications without adequate indication or monitoring, and in the absence of a treatment plan with objectives.

D. Respondent failed to thoroughly or adequately evaluate or assess the cause of RB's complaints of pain.

E. Respondent made no effort to exclude drug diversion or abuse by RB, and took no history pertaining to drug or alcohol use.

F. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for RB.

24. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2266 of the Code in that he failed to keep adequate and accurate records for patient RB:

A. Respondent's medical records fails to adequately document a patient history, medical examination, evaluation, assessment, treatment plan, objectives, informed consent, or rationale for the medications prescribed. The records that were created are largely illegible, and are devoid of information setting forth Respondent's decision making process for his treatment of RB.

B. Respondent's record fails to adequately document a medical basis or indication for the ongoing prescription of opioid narcotics and sedatives, or to document physical examination findings that supported his clinical diagnosis.

25. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed dose opioid and sedative medications for patient RB, in the absence of an appropriate prior medical examination and a medical indication, and without taking steps to monitor the patient.

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FOURTH CAUSE FOR DISCIPLINE

Patient YD

(Unprofessional Conduct/Gross Negligence/Negligence/Excessive Prescribing/Inadequate Records)

26. Respondent saw 27 year old Patient YD[7] on six occasions between August 4, 2011 and February 23, 2012. Respondent's largely illegible medical record for YD notes a history of auto accident, gunshot wound and a back injury; no further history or assessment of these events is documented. The record reflects no physical examination. No other medical history was obtained. Respondent made no assessment or evaluation of YD's pain complaints. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse was taken or documented. Respondent's diagnosis for YD was chronic complex pain syndrome, bronchitis and osteoarthritis.

27. Over the course of his treatment of YD, Respondent prescribed Norco, oxycodone, Soma, Valium, and promethazine with codeine cough syrup. Respondent's chart fails to document any rationale for the prescriptions. Respondent stated during his Medical Board interview that he prescribed the drugs requested by YD.

28. At no time during his treatment of YD did Respondent take steps to objectify his complaint of pain, and he failed to obtain lab studies, toxicology screening, or urinalysis. He never obtained YD's past medical records. Respondent failed to adequately consider or evaluate the source of YD's reported pain.

29. Respondent's medical record for YD fails to document physical examination or findings. His record contains insufficient physical findings to support his clinical diagnosis. His chart fails to adequately document the basis for his prescription of large doses of opiate and sedative medications, or to assess whether YD demonstrated drug-seeking or aberrant drug behavior.

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[7] Respondent stated in his Medical Board interview that he believed that YD was referred to him by the "B" family set forth above.

30. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent undertook to treat Patient YD for severe chronic pain, prescribing high doses of narcotic and sedative medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent diagnosed and treated YD for bronchitis without an adequate history, physical or clinical evidence to support the diagnosis.

C. Respondent prescribed potentially dangerous or even lethal combinations of narcotic and sedative medications without adequate indication or monitoring, and in the absence of a treatment plan with objectives.

D. Respondent failed to thoroughly or adequately evaluate or assess the cause of YD's complaints of pain.

E. Respondent made no effort to exclude drug diversion or abuse by YD, and took no history pertaining to drug or alcohol use.

F. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for YD.

31. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2266 of the Code in that he failed to keep adequate and accurate records for patient YD:

A. Respondent's medical records fails to adequately document a patient history, medical examination, evaluation, assessment, treatment plan, objectives, informed consent, or rationale for the medications prescribed. The records that were created are largely illegible, and are devoid of information setting forth Respondent's decision making process for his treatment of YD.

B. Respondent's record fails to adequately document a medical basis or indication for the ongoing prescription of large quantities of opioid narcotics and sedatives, or to document physical examination findings that supported his clinical diagnosis.

32. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed high dose opioid and sedative medications for patient YD, in the absence of an appropriate prior medical examination and a medical indication, and without taking steps to monitor the patient.

FIFTH CAUSE FOR DISCIPLINE

Patient RK

(Unprofessional Conduct/Gross Negligence/Negligence/Excessive Prescribing/False or Inadequate Records)

33. Respondent saw 60 year old Patient RK on six occasions between January 13, 2012 and June 5, 2012. The medical records produced by Respondent for RK, which are virtually identical for each purported visit, are more legible than his other records, and contain more detail in the areas of vital signs and physical examination. During the course of his Medical Board interview, Respondent admitted that he "reconstructed" RK's chart when he received a request for records from the Medical Board. The "reconstructed" chart for RK notes persistent pain, cough and spasms. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse was taken or documented. Respondent's diagnosis, as documented in the "reconstructed" record for RK over the course of his treatment was osteoarthritis, back/muscle spasms, bronchitis and on one occasion, anxiety

34. Over the course of his treatment of RK, Respondent prescribed oxycodone, Norco, Valium, Xanax[8], and promethazine with codeine cough syrup.

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[8] Xanax is a trade name for alprazolam, a psychotropic benzodiazepine. 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. 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

(continued...)

35. At no time during his treatment of RK did Respondent take steps to objectify his complaints of pain, and he failed to obtain lab studies, toxicology screening, or urinalysis. He never obtained RK's past medical records. Respondent failed to adequately consider or evaluate the source of RK's reported pain.

36. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent undertook to treat Patient RK for severe chronic pain, prescribing high doses of narcotic and sedative medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent prescribed potentially dangerous or even lethal combinations of narcotic and sedative medications without adequate indication or monitoring, and in the absence of a treatment plan with objectives.

C. Respondent failed to thoroughly or adequately evaluate or assess the cause of RK's complaints of pain.

D. Respondent made no effort to exclude drug diversion or abuse by RK, and took no history pertaining to drug or alcohol use.

E. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for RK.

37. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2234(e), and/or 2262, and/or 2266, of the Code in that he failed to create and maintain adequate and accurate records for patient RK, and created a false medical record for Patient RK:

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habituation and dependence.

38. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed high dose opioid and sedative medications for patient RK, in the absence of an appropriate prior medical examination and a medical indication, without adequate documentation, and without taking steps to monitor the patient.

SIXTH CAUSE FOR DISCIPLINE

Patient WD

(Unprofessional Conduct/Gross Negligence/Negligence/Excessive Prescribing/Inadequate/False Records)

39. Respondent saw 52 year old Patient WD on four occasions between January 21, 2012 and May 16, 2012. The medical records produced by Respondent for WD, which are virtually identical for each purported visit, are more legible than his other records, and contain more detail in the areas of vital signs and physical examination. During the course of his Medical Board interview, Respondent admitted that he "reconstructed" WD's chart when he received a request for records from the Medical Board. The "reconstructed" chart for WD notes persistent back pain and spasms and bronchitis. No prior medical records were obtained, no imaging studies or laboratory tests were ordered or considered, and no history of opioid use or substance abuse was taken or documented. Respondent's diagnosis, as documented in the "reconstructed" record for WD over the course of his treatment was lumbosacral strain and bronchitis.

40. Over the course of his treatment of WD, Respondent prescribed oxycodone, Norco, promethazine with codeine cough syrup, and on one occasion, Methadone[9].

[9] Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. 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.

41. At no time during his treatment of WD did Respondent take steps to objectify his complaints of pain, and he failed to obtain lab studies, toxicology screening, or urinalysis. He never obtained WD's past medical records. Respondent failed to adequately consider or evaluate the source of WD's reported pain.

42. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent undertook to treat Patient WD for chronic pain, prescribing high doses of narcotic medications, without conducting the necessary examination, evaluation and assessment to support his diagnosis or the prescription of medication.

B. Respondent failed to thoroughly or adequately evaluate or assess the cause of WD's complaints of pain.

C. Respondent made no effort to exclude drug diversion or abuse by WD, and took no history pertaining to drug or alcohol use.

D. Respondent failed to obtain imaging studies, urinalysis, toxicology testing, or basic laboratory testing for WD.

43. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234(c), and/or 2234(e), and/or 2262, and/or 2266, of the Code in that he failed to create and maintain adequate and accurate records for patient WD, and created a false medical record for Patient WD.

44. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that he inappropriately and excessively prescribed high dose opioid medications for patient WD, in the absence of an appropriate prior medical examination and a medical indication, and without taking steps to monitor the patient.

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PRAYER

WHEREFORE, Complainant prays that a hearing be held and that the Board issue an order:

1. Revoking or suspending physician's and surgeon's certificate number A23867 issued to Collin Leong, M.D.;

2. Prohibiting Collin Leong, M.D., from supervising physician's assistants;

3. Ordering Collin Leong, M.D., if placed on probation, to pay the costs of probation monitoring;

4. Taking such other and further action as may be deemed proper and appropriate.

DATED: April 16, 2013

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

Complainant