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

In the Matter of the Accusation Against:	)	
	)	
JAMES KIRK CLOPTON, M.D.	)	MBC No. 02-2011-216149
	)	
Physician's & Surgeon's	)	
Certificate No. G 69788	)	
	)	
	)	
Petitioner.	)	
	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Petitioner, James Kirk Clopton, M.D., and the time for action having expired at 5 p.m. on October 17, 2014, the petition is deemed denied by operation of law.

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

In the Matter of the Accusation Against:	)	
	)	MBC No. 02-2011-216149
JAMES KIRK CLOPTON, M.D.	)	
	)	
Physician's and Surgeon's Certificate No. G69788	)	**ORDER GRANTING STAY**
	)	
	)	(Government Code Section 11521)
	)	
Petitioner.	)	

Petitioner, James Kirk Clopton, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of September 18, 2014.

Execution is stayed until October 17, 2014.

This stay is granted solely for the purpose of allowing the Petitioner to file a Petition for Reconsideration.

DATED: September 16, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: **JAMES KIRK CLOPTON, M.D.** 989 Governor Drive, Suite 101 El Dorado Hills, CA 95762 Physician's and Surgeon's Certificate No. G-69788 Respondent.	Case No. 02-2011-216149 **DEFAULT DECISION AND ORDER** [Gov. Code, § 11520]

FINDINGS OF FACT

1. On or about March 28, 2014, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 02-2011-216149 against James Kirk Clopton, M.D. (Respondent) before the Medical Board of California.

2. On or about September 17, 1990, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G-69788 to Respondent. That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2016, unless renewed. Attached hereto as Exhibit A and incorporated herein is a Certification of Licensure.

3. On or about March 28, 2014, Kelly Montalbano, an employee of the Complainant

Agency, served by Certified Mail a copy of Accusation No. 02-2011-216149, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 989 Governor Drive, Suite 101, El Dorado Hills, California 95762. Respondent was also served by Certified Mail at 1037 Suncast Lane, Suite 100, El Dorado Hills, California 95762. A copy of the Accusation, the related documents, and Declaration of Service are attached as Exhibit B, and are incorporated herein by reference.

4. In April 2014, one package of the aforementioned documents was returned by the U.S. Postal Service marked as unable to forward and the other package was returned by the U.S. Postal Service marked as unclaimed.

5. On or about April 28, 2014, Michelle Solario, an employee of the Complainant Agency, served by Certified Mail a copy of the Accusation No. 02-2011-216149, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address at 6485 Buckeye Lane, Granite Bay, California 95746. A copy of the Declaration of Service is attached as Exhibit C, and is incorporated herein by reference.

6. On or about May 15, 2014, the Board received a U.S. Postal Service return receipt, indicating that Respondent received the documents referred to in paragraph 5 above on or about May 13, 2014. A true and correct copy of said return receipt is attached as Exhibit D and is incorporated herein by reference.

7. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

8. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

9. Respondent failed to file a Notice of Defense within 15 days after service upon him

of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 02-2011-216149.

10. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

11. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing, and based on Respondent's express admissions by way of default and the evidence before it contained in Exhibits A, B, C and D, as well as the attached declaration of Michael McBeth, M.D. in Exhibit E, finds that the allegations in Accusation No. 02-2011-216149 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent James Kirk Clopton, M.D. has subjected his Physician's and Surgeon's Certificate No. G-69788 to discipline.

2. A copy of the Accusation and the related documents and Declarations of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate based upon the following violations alleged in the Accusation:

a. Respondent was grossly negligent in the care and treatment of his patients in violation of Business and Professions code section 2234, subdivision (b).

b. Respondent was repeatedly negligent in the care and treatment of his patients in violation of Business and Professions code section 2234, subdivision (c).

c. Respondent prescribed controlled substances and dangerous drugs without an appropriate prior examination of his patients in violation of Business and Professions code section 2242.

d. Respondent failed to maintain adequate and accurate medical records for his patients in violation of Business and Professions Code section 2266.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G-69788, heretofore issued to Respondent James Kirk Clopton, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on September 18, 2014.

It is so ORDERED August 19, 2014

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
KIMBERLY KIRCHMEYER
EXECUTIVE DIRECTOR

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

In the Matter of the Accusation Against: **JAMES KIRK CLOPTON, M.D.** 989 Governor Drive, Suite 101 El Dorado Hills, CA 95762 Physician's and Surgeon's Certificate G-69788, Respondent.	Case No. 02-2011-216149 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about September 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate number G-69788 to James Kirk Clopton, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2014, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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

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

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"(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.

"(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. "

6. Section 2228 of the Code states:

AThe authority of the board or a division of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

A(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or division or the administrative law judge.

A(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the division. If an examination is ordered, the board or division shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

A(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

A(d) Providing the option of alternative community service in cases other than violations relating to quality of care, as defined by the Division of Medical Quality.@[1]

7. Section 2242 of the Code states:

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

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

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

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

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

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

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

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§ 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

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

8. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.@

DRUGS

9. Norco, a trade name for the narcotic Hydrocodone Bitartrate (also known as Dihydrocodeinone) combined with the non-narcotic substance Acetaminophen, is a Schedule III controlled substance within the meaning of Health and Safety Code section 11056(e)(3), and a dangerous drug as defined in section 4022 of the Code.

10. Percocet, a trade name for the combination of the opiate oxycodone combined with Acetaminophen, is a Schedule II controlled substance within the meaning of Health and Safety Code section 11055(b)(1)(N), and is a dangerous drug as defined in section 4022 of the Code.

11. Clonazepam, a generic name for the drug Klonopin, is classified as a benzodiazepine used primarily in the management of seizures. Clonazepam is a Federal Schedule IV Controlled Substance. Clonazepam is a Dangerous Drug as defined by California Business and Professions Code section 4022.

12. Hydrocodone with acetaminophen, the generic name for the drugs Vicodin, Norco and others, is classified as an analgesic opiate agonist combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Federal Schedule III Controlled Substance. Hydrocodone with acetaminophen is a Dangerous Drug as defined by California Business and Professions Code section 4022.

13. Methadone is the generic name for the drugs Methadose and others It is classified as a synthetic opiate agonist and substance abuse agent indicated for the treatment of severe pain, opiate dependence and opiate withdrawal. Methadone is a Federal Schedule II Controlled Substance. Methadone is a Dangerous Drug as defined by California Business and Professions Code section 4022. Practitioners who use methadone for the treatment of opiate dependence must register and comply with Title 21 United States Code section 823(g).

14. Alprazolam is the generic name for the drug Xanax. Alprazolam is classified as a benzodiazepine indicated for the treatment of anxiety disorders. Alprazolam is a Federal Schedule IV Controlled Substance. Alprazolam is a Dangerous Drug as defined by California Business and Professions Code section 4022.

15. Buprenorphine with naloxone is the generic name for the drug Suboxone. Buprenorphine with naloxone is classified as a substance abuse agent combination product indicated for the treatment of opioid dependence. Buprenorphine with naloxone is a Federal Schedule III Controlled Substance. Buprenorphine with naloxone is a Dangerous Drug as defined by California Business and Professions Code section 4022. Practitioners using buprenorphine with naloxone to treat opiate dependence must comply with Title 21, United States Code section 823(g).

16. Methylphenidate (Methylin, Ritalin) is a central nervous system stimulant that is chemically similar to the amphetamines. The peripheral pharmacologic actions of methylphenidate are milder than those of the amphetamines; it has more noticeable effects on mental function than on motor activities. Methylphenidate is clinically used for narcolepsy and as adjunctive treatment in children with attention deficit hyperactivity disorder (ADHD). It is occasionally used off-label for post-stroke depression or other depressive disorders refractory to other treatments. Methylphenidate and other stimulants are highly effective for the treatment of ADHD, with few comparative differences in efficacy. Methylphenidate has been shown to have a strong effect on measures of attention, distractibility, and impulsivity (effects sizes: 0.75–0.84; mean 0.78) and social and classroom behavior (effect sizes: 0.63-0.86; mean 0.81).

17. Propoxyphene (Darvon) is a schedule C-IV controlled substance. Propoxyphene is a synthetic opiate agonist. Structurally, propoxyphene is more similar to methadone than to morphine. Compared with codeine, propoxyphene is one-half to two-thirds as potent an analgesic. An equivalent analgesic dose of propoxyphene to morphine 10 mg IV would be too toxic to administer. High doses of propoxyphene are limited by serious side effects and toxic psychosis. Propoxyphene is as effective or is less effective than 3-60 mg of codeine or 600 mg of aspirin. In addition, overdoses of propoxyphene can be more difficult to reverse than overdoses

of traditional opiates. Propoxyphene exerts little or no antitussive activity and may cause an increased incidence of seizures compared to other opiate agonists.

18. Oxycodone with acetaminophen is the generic name for the drugs Endocet, Percocet and others. Oxycodone with acetaminophen is classified as an analgesic opiate agonist combination product used to treat moderate to moderately severe pain. Oxycodone with acetaminophen is a Federal Schedule II Controlled Substance. Oxycodone with acetaminophen is a Dangerous Drug as defined by California Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(b)]
(Gross Negligence - Patient J.M.)

Patient J. M.

19. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient J.M. The circumstances are as follows:

20. On approximately May 10, 2011 the Medical Board of California received a complaint from patient J. M. regarding Respondent. J.M., was a 40-year-old woman when she first saw Respondent for treatment on May 24, 2007. She presented with a diagnosis of anxiety and depression. Respondent prescribed Cymbalta and Lunesta to her. The date of her last visit with Respondent reflected in the patient charts was November 2009 in which Respondent prescribed Zoloft and Librium. The patient alleged that Respondent prescribed large amounts of Librium to her even though she was alcoholic and this caused her physical problems.

21. J.M. also alleged that Respondent supplied drugs to her friend (C.R.) who sought out Respondent to give her illicit drugs. C.R. claimed that Respondent would give prescriptions easily for illegitimate reasons.

22. Based on this complaint, the Medical Board ran a CURES identifying several other patients of Respondent's who were receiving large amounts of prescription medications including clonazepam, lorazepam, diazepam, and hydrocodone, among others. Medical Board investigators requested from Respondent records for several of those patients including A.L., T.O., and K.W.

Respondent had no records for A.L. and T.O. Respondent claimed that he did not have several of these patient records which were lost during a move of his office and that some may have been lost during a break-in of his office during which medical records may have been stolen as well as prescription pads.

23. The Medical Board during the course of its investigation also found that the Federal Drug Enforcement Administration (DEA) was also conducting an investigation into Respondent's prescribing practices. Medical Board investigators contacted DEA and found that a search warrant had been executed on Respondent's office in January 2011 during which multiple patient records were seized as evidence. On the date of this search by DEA, Respondent surrendered his DEA registration.

24. In a statement to DEA investigators on the day of the search, Respondent stated the following: Respondent is a psychiatrist who treats patients for psychiatric issues and provides drug treatment. He stated he would treat an existing patient for other physical ailments and would provide narcotics to his patients for pain relief or chronic injury. Respondent did not conduct physical examinations of the patients in his office. Respondent had no medical equipment in his office except for a blood pressure cuff and would rely on patients to supply medical records from previous treating physicians. Respondent would not call the past medical providers to confirm their diagnosis. Respondent would charge these patients $250 for an initial visit and $100 for follow-up visits. Respondent would not accept insurance.

25. Respondent prescribed controlled substances for his patients' complaints of pain that he never examined physically to confirm a diagnosis. Respondent did not write any confirmation in the chart notes of the patients' diagnosis. There is no evidence Respondent monitored the dispensing of these prescription medications nor did he do routine urine screening to determine if the patient was using the substances he was prescribing or to ensure the patient was not using illicit substances.

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26. Respondent demonstrated an erratic prescribing pattern for his patients. He would prescribe opiates and benzodiazepines in regular amounts to his patients one day followed by a similar amount often 2 to 3 days later. The CURES reports also demonstrate that Respondent was under representing in the chart notes the amount of medications he was actually prescribing for the patients.

27. Respondent was attempting to use controlled substances for pain management in these patients in addition to managing coexistent psychiatric illnesses. Respondent failed to perform physical examinations, substance abuse histories, or diagnostic tests on any of his patients.

28. He failed to coordinate with any of the primary care physicians. Respondent failed to develop concise treatment plans with clear objectives for his patients or to develop rehabilitation programs for pain management or opiate dependence as was necessary. He failed to perform any periodic chart review of the patients to ensure that they were not being over prescribed medications. Respondent also failed to seek out any consultation for pain management.

29. Respondent's medical records for his patients were below the standard of care. The patient charts demonstrate large gaps in dates between appointments for each patient. It is unclear from the charting whether Respondent performed patient examinations or simply continued to prescribe medications to the patients without visits. His chart notes do not contain any explanation or rationale for his treatment decisions. He changed medications and quantities of medications including antidepressants and benzodiazepines without clear indications as to the reason for these increases and/or shifts in medication. Respondent appears to present no treatment plan for these patients in his chart notes. Respondent failed to show any progressive increase in dosages with his patients especially in the circumstances of anxiety, instead giving large dosages from the beginning of treatment. Respondent's chart notes also do not reflect the CURES reports which indicate how much medication Respondent was prescribing to his patients. Patient charts also fail to include any responses the patients were having to medication, such as any adverse consequences or side effects.

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30. Respondent's care and treatment of J.M. was grossly negligent in the following respects:

1. There is no initial treatment plan in the records.

2. Respondent did no physical examination of the patient during the first 6 months of treatment. He failed to order X rays, MRIs or CT scans, and failed to refer the patient to another doctor or for physical therapy.

3. The patient's chart is missing medical records.

4. Respondent treated the patient's pain based only on the patient's reported history. He did not consult with other physicians who had treated the patient. Respondent made no radiologic investigation. Respondent failed to determine a more precise etiology of the patient's pain.

5. Respondent treated the patient's pain solely with prescription medications. He did not consider treatments such as physical therapy or stress reduction.

6. Respondent failed to conduct an assessment of the patient's addiction risk through he was prescribing narcotic therapy for chronic pain.

7. Respondent did not conduct any drug screening.

8. Respondent failed to obtain a thorough history of the patient's substance abuse problem, failed to consult and consider collateral sources, and failed to contact the patient's prior treating physician.

31. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]

(Repeated Negligent Acts - Patient J.M.)

32. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient J.M. The circumstances are as follows:

33. Paragraphs 19 through 30 are repeated here as more fully set forth above.

34. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of J.M. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

THIRD CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2242]
(Prescribing Without Appropriate Prior Exam - Patient J.M.)

35. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient J.M. prior to prescribing controlled substances and dangerous drugs.

36. Paragraphs 19 through 30 are repeated here as more fully set forth above.

37. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of J.M. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

FOURTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2266]
(Inaccurate Medical Records - Patient J.M.)

38. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient J.M. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

39. Paragraphs 19 through 30 are repeated here as more fully set forth above.

40. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of J.M. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

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FIFTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(b)]
(Gross Negligence - Patient C.S.)

Patient C.S.

41. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient C.S. The circumstances are as follows:

42. On June 20, 2011 the Medical Board received a complaint filed by A.S., husband of deceased patient, C.S.

43. C.S. was a 39-year-old woman who began treatment with Respondent in 1996 for depression and attention deficit disorder. From 1998 to 2010, C.S. would travel from her home in Grass Valley to Respondent's Golden Hills Psychiatry clinic in El Dorado Hills. Respondent initially prescribed Ritalin and Paxil. Respondent treated C.S. in 2007 with Norco for pain management of a herniated disc. C.S. paid cash for her appointments. Respondent conducted only minimal examination of C.S.

44. In approximately 2007, C.S. became erratic, hearing voices, talking to herself, and believing people were trying to kill her. C.S.'s family emailed Respondent regarding her behavior and the effects of the medications he was prescribing. The family reached out to Respondent on several occasions to explain to him the changes in her behavior. However Respondent's chart notes for C.S. do not include any notation of the family's concerns, any awareness on the behalf of Respondent about the family's contact with him, and no indication from Respondent that he would address these reports he received from the family. Respondent was dismissive of the family's concerns.

45. In approximately 2008, C.S. was admitted to the hospital after having a seizure. The seizure was induced by medication prescribed by Respondent (alprazolam and methylene) and alcohol consumption. Respondent failed to recognize that the seizure was related to substance withdrawal due to medications that Respondent was prescribing. Rather than check with the physician who had prescribed previously to C.S. for her seizure disorder, Respondent continued

to prescribe Xanax and Darvon until the patient ultimately died from an overdose in August 2010 from acute alprazolam and propoxyphene toxicity.

46. Respondent's care and treatment of C.S. was grossly negligent in the following respects:

1. There is no initial treatment plan in the records.

2. Respondent did no physical examination of the patient during the first 6 months of treatment. He failed to order X rays, MRIs or CT scans, and failed to refer the patient to another doctor or for physical therapy.

3. The patient's chart is missing medical records.

4. Respondent treated the patient's pain based only on the patient's reported history. He did not consult with other physicians who had treated the patient. Respondent made no radiologic investigation. Respondent failed to determine a more precise etiology of the patient's pain.

5. Respondent treated the patient's pain solely with prescription medications. He did not consider treatments such as physical therapy or stress reduction.

6. Respondent failed to conduct an assessment of the patient's addiction risk although he was prescribing narcotic therapy for chronic pain.

7. Respondent did not conduct any drug screening.

8. Respondent failed to obtain a thorough history of the patient's substance abuse problem, failed to consult and consider collateral sources, and failed to contact the patient's prior treating physician.

47. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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SIXTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts - Patient C.S.)

48. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient C.S. The circumstances are as follows:

49. Paragraphs 41 through 46 are repeated here as more fully set forth above.

50. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of C.S. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

SEVENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2242]
(Prescribing Without Appropriate Prior Exam - Patient C.S.)

51. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient C.S. prior to prescribing controlled substances and dangerous drugs.

52. Paragraphs 41 through 46 are repeated here as more fully set forth above.

53. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of C.S. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

EIGHTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2266]
(Failure to Maintain Adequate and Accurate Medical Records – Patient C.S.)

54. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient C.S. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

55. Paragraphs 41 through 46 are repeated here as more fully set forth above.

56. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of C.S. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

NINTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]

(Gross Negligence - Patient K.W.)

Patient K.W.

57. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient K.W. The circumstances are as follows:

58. K.W. was an 18-year-old woman when she first sought treatment from Respondent for her depression on February 26, 2009. Her treatment continued through August 24, 2010.

59. Respondent prescribed Subutex for pain management of the patient's fibromyalgia even though Respondent knew the patient had a substance abuse problem.

60. Respondent prescribed controlled substances for his patient's complaints of pain that he never examined physically to confirm a diagnosis. Respondent did not write any confirmation in the chart notes of the patient's diagnosis. There is no evidence Respondent monitored the dispensing of these opiates nor did he do routine urine screening to determine if the patient was using the substances he was prescribing or to ensure the patient was not using illicit substances.

61. Respondent demonstrated an erratic prescribing pattern for his patient. He would prescribe opiates and benzodiazepines in regular amounts to his patient one day followed by a similar amount often 2 to 3 days later. The CURES reports also demonstrate that Respondent was under representing in the chart notes the amount of medications he was actually prescribing for the patient.

62. Respondent was attempting to use controlled substances for pain management in this patient in addition to managing coexistent psychiatric illnesses. Respondent failed to perform physical examinations, substance abuse histories, or diagnostic tests on any of his patients.

63. He failed to coordinate with any primary care physician. Respondent failed to develop concise treatment plans with clear objectives for his patient or to develop rehabilitation programs for pain management or opiate dependence as was necessary. He failed to perform any

periodic chart review of the patient to ensure that she was not being over prescribed medications. Respondent also failed to seek out any consultation for pain management.

64. Respondent's medical records for his patient was below the standard of care. The patient charts demonstrate large gaps in dates between appointments for each the patient. It is unclear from the charting whether Respondent performed patient examinations or simply continued to prescribe medications to the patient without visits. His chart notes do not contain any explanation or rationale for his treatment decisions. He changed medications and quantities of medications including antidepressants and benzodiazepines without clear indications as to the reason for these increases and/or shifts in medication. Respondent appears to present no treatment plan for this patient in his chart notes. Respondent failed to show any progressive increase in dosages with the patient especially in the circumstances of anxiety, instead giving large dosages from the beginning of treatment. Respondent's chart notes also do not reflect the CURES reports which indicate how much medication Respondent was prescribing to the patient. Patient charts also fail to include any responses the patient was having to medication, such as any adverse consequences or side effects.

65. Respondent's care and treatment of K.W. was grossly negligent in the following respects:

1. There is no initial treatment plan in the records.

2. Respondent did no physical examination of the patient during the first 6 months of treatment. He failed to order X rays, MRIs or CT scans, and failed to refer the patient to another doctor or for physical therapy.

3. The patient's chart is missing medical records.

4. Respondent diagnosed the patient's painful condition based only on the patient's reported history. He did not consult with other physicians who had treated the patient. Respondent made no radiologic investigation. Respondent failed to determine a more precise etiology of the patient's pain.

5. Respondent treated the patient's pain solely with prescription medications. He did not consider treatments such as physical therapy or stress reduction.

6. Respondent failed to conduct an assessment of the patient's addiction risk although he was prescribing narcotic therapy for her chronic pain.

7. Respondent did not conduct any drug screening.

8. Respondent failed to obtain a thorough history of any possible substance abuse, failed to consult and consider collateral sources, and failed to contact the patient's prior treating physician.

66. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

TENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts - Patient K.W.)

67. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient K.W. The circumstances are as follows:

68. Paragraphs 57 through 65 are repeated here as more fully set forth above.

69. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of K.W. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

ELEVENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2242]
(Prescribing Without Appropriate Prior Exam - Patient K.W.)

70. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient K.W. prior to prescribing controlled substances and dangerous drugs.

71. Paragraphs 57 through 65 are repeated here as more fully set forth above.

72. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of K.W. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

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TWELFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]

(Failure to Maintain Adequate and Accurate Medical Records – Patient K.W.)

73. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient K.W. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

74. Paragraphs 57 through 65 are repeated here as more fully set forth above.

75. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of K.W. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

THIRTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]

(Gross Negligence - Patient D.A.)

Patient D.A.

76. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient D.A. The circumstances are as follows:

77. D.A. began treatment with Respondent in January 24, 2006. Her diagnosis was crippling anxiety. Respondent's last patient chart was September 4, 2012.

78. D.A. reported that she had been referred to Respondent through family members. After an initial in person appointment with Respondent, her subsequent appointments were over the telephone and lasted usually no longer than three minutes. Most of the telephone appointments lasted one minute. During these telephone appointments Respondent asked the patient how she was doing, would ask for her credit card information, and would prescribe medications such as Valium.

79. In 2012, Respondent recommended that D.A. take Percocet, but the reasons or purpose for that recommendation is not clear in Respondent's notes.

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80. Respondent was attempting to use controlled substances for pain management in this patient in addition to managing coexistent psychiatric illnesses. Respondent failed to perform physical examinations, substance abuse histories, or diagnostic tests on any of the patient.

81. He failed to coordinate with any of the primary care physicians. Respondent failed to develop concise treatment plans with clear objectives for his patients or to develop rehabilitation programs for her anxiety or pain management. He failed to perform any periodic chart review of the patient to ensure that she was not being over prescribed medications. Respondent also failed to seek out any consultation for pain management.

82. Respondent's medical records for his patient was below the standard of care. The patient charts demonstrate large gaps in dates between appointments for the patient. It is clear from the charting that Respondent failed to performed patient examinations, but simply continued to prescribe medications to the patient without visits. His chart notes do not contain any explanation or rationale for his treatment decisions. He changed medications and quantities of medications including antidepressants and benzodiazepines without clear indications as to the reason for these increases and/or shifts in medication. Respondent appears to present no treatment plan for the patient in his chart notes. Respondent failed to show any progressive increase in dosages with his patient especially in the circumstances of anxiety, instead giving large dosages from the beginning of treatment. Respondent's chart notes also do not reflect the CURES reports which indicate how much medication Respondent was prescribing to the patient. Patient charts also fail to include any responses the patient was having to medication, such as any adverse consequences or side effects.

83. Respondent's care and treatment of D.A. was grossly negligent in the following respects:

1. There is no initial treatment plan in the records.

2. Respondent only saw the patient on her first visit. All subsequent contact was by telephone with no physical examination. Respondent failed to order X rays, MRIs or CT scans, and failed to refer her to another doctor or for physical therapy.

3. The patient's chart is missing medical records.

4. Respondent diagnosed the patient's condition based only on the patient's reported history. He did not consult with other physicians who had treated the patient. Respondent made no radiologic investigation. Respondent failed to determine a more precise etiology of the patient's pain or causes of depression and anxiety.

5. Respondent treated the patient's diagnoses solely with prescription medications. He did not consider treatments such as physical therapy or stress reduction.

6. Respondent failed to conduct an assessment of the patient's addiction risk.

7. Respondent did not conduct any drug screening.

8. Respondent failed to obtain a thorough history of the patient's controlled substance use, failed to consult and consider collateral sources, and failed to contact the patient's prior treating physician.

84. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FOURTEENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts - Patient D.A.)

85. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient D.A. The circumstances are as follows:

86. Paragraphs 76 through 83 are repeated here as more fully set forth above.

87. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of D.A. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FIFTEENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2242]
(Prescribing Without Appropriate Prior Exam - Patient D.A.)

88. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient D.A. prior to prescribing controlled substances and dangerous drugs.

89. Paragraphs 76 through 83 are repeated here as more fully set forth above.

90. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of D.A. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

SIXTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]

(Failure to Maintain Adequate and Accurate Medical Records- Patient D.A.)

91. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient D.A. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

92. Paragraphs 76 through 83 are repeated here as more fully set forth above.

93. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of D.A. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

SEVENTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]

(Gross Negligence - Patient T.O.)

Patient T.O.

94. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient T.O. The circumstances are as follows:

95. T.O. was a 46-year-old man when he first saw Respondent on August 29, 2007 for treatment of depression and chronic pain. Respondent prescribed OxyContin. Treatment continued through 2010 according to Respondent's treatment records.

96. Respondent prescribed OxyContin, Neurontin, and Nuvigil.

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97. Respondent failed to do a proper evaluation of the patient including an assessment of his pain, assessment of the patient's physical and psychological function, substance abuse history, patient history of prior pain treatment, and assessment of any underlying or coexisting diseases or conditions.

98. Respondent failed to establish or document a treatment plan and objectives for the patient. Treatment was purely based on subjective symptoms of the patient.

99. Respondent continued to prescribe and make adjustments to high dose opiate therapy without objective measurements of its effectiveness, and without evaluation of the side effects. Respondent failed to maintain proper follow-up of the patient's condition through the course of treatment.

100. There is no documentation in the record that the patient was informed of the risks and dangers of opiate therapy or that these risks and dangers were discussed with the patient.

101. There is no documentation of appropriate testing results such as lab tests, specialty testing, MRIs or CT scans. Respondent also failed to consult with other physicians regarding the care of the patient including lack of contact with the patient's primary care physician and no indication that consultant services were utilized in the treatment plan.

102. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

EIGHTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]

(Repeated Negligent Acts – Patient T.O.)

103. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient T.O. The circumstances are as follows:

104. Paragraphs 94 through 101 are repeated here as more fully set forth above.

105. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of T.O. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

NINETEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2242]

(Prescribing Without Appropriate Prior Exam – Patient T.O.)

106. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient T.O. prior to prescribing controlled substances and dangerous drugs.

107. Paragraphs 94 through 101 are repeated here as more fully set forth above.

108. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of T.O. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

TWENTIETH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]

(Failure to Maintain Adequate and Accurate Medical Records – Patient T.O.)

109. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient T.O. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

110. Paragraphs 94 through 101 are repeated here as more fully set forth above.

111. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of T.O. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

TWENTY-FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]

(Gross Negligence – Patient A.L.)

Patient A.L.

112. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient A.L. The circumstances are as follows:

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113. A.L. was a 20-year-old woman when she first began treatment with Respondent on August 21, 2007 with a diagnosis of anxiety and depression. Respondent's last treatment note for A.L. was on February 5, 2010 when he referred her to the Auburn pain clinic.

114. Respondent prescribed methadone, Vicodin, Ultram, Cymbalta, Effexor, Xanax, Pristiq, cannabis, Clonidine, Percocet, and Subutex.

115. Respondent treated A.L. for opiate dependency, anxiety and depression, and pain and anxiety all concurrently. He first prescribed methadone in pill form then later switched A.L. to Subutex in 2008.

116. Respondent failed to do a proper evaluation of the patient including an assessment of her pain, assessment of the patient's physical and psychological function, substance abuse history, patient history of prior pain treatment, and assessment of any underlying or coexisting diseases or conditions.

117. Respondent failed to establish or document a treatment plan and objectives for the patient. Treatment was purely based on subjective symptoms of the patient.

118. Respondent continued to prescribe and make adjustments to high dose opiate therapy without objective measurements of its effectiveness, and without evaluation of the side effects. Respondent failed to maintain proper follow-up of the patient's condition through the course of treatment.

119. There is no documentation in the record that the patient was informed of the risks and dangers of opiate therapy or that these risks and dangers were discussed with the patient.

120. There is no documentation of appropriate testing results such as lab tests, specialty testing, MRIs or CT scans. Respondent also failed to consult with other physicians regarding the care of the patient including lack of contact with the patient's primary care physician and no indication that consultant services were utilized in the treatment plan.

121. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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TWENTY-SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]

(Repeated Negligent Acts – Patient A.L.)

122. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient A.L. The circumstances are as follows:

123. Paragraphs 112 through 120 are repeated here as more fully set forth above.

124. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of A.L. in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

TWENTY-THIRD CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2242]

(Prescribing Without Appropriate Prior Exam – Patient A.L.)

125. Respondent is subject to disciplinary action under section 2242 of the Code in that he failed to conduct an appropriate prior examination of patient A.L. prior to prescribing controlled substances and dangerous drugs.

126. Paragraphs 112 through 120 are repeated here as more fully set forth above.

127. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of A.L. in violation of section 2242 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]

(Failure to Maintain Adequate and Accurate Medical Records – Patient A.L.)

128. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for patient A.L. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's condition, medications prescribed, and treatment notes.

129. Paragraphs 112 through 120 are repeated here as more fully set forth above.

130. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of A.L. in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]

(Repeated Negligent Acts – Patients J.M., C.S., K.W., D.A., T.O. and A.L.)

131. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patients J.M., C.S., K.W., D.A., T.O., and A.L. The circumstances are as follows:

132. Paragraphs 19 through 120 are repeated here as more fully set forth above.

133. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of these patients in violation of section 2234(c) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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's and Surgeon's Certificate Number G69788, issued to James Kirk Clopton, M.D.

2. Revoking, suspending or denying approval of his authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering him 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: March 28, 2014

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

Complainant

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