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

In the Matter of the Accusation Against:	)	
	)	
JOSEPH RALPH SICIGNANO, M.D.	)	**Case No. 05-2011-213392**
	)	
Physician's and Surgeon's Certificate No. G 21095	)	
	)	
Respondent.	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on November 22, 2013

IT IS SO ORDERED October 24, 2013.

MEDICAL BOARD OF CALIFORNIA

By: ______________________
Dev Gnanadev, M.D., Vice Chairman
Panel B

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

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In the Matter of the Accusation Against: **JOSEPH RALPH SICIGNANO, M.D.** **5233 Elvira Road** **Woodland Hills, CA 91364** **Physician's and Surgeon's Certificate No. G 21095** Respondent.	Case No. 05-2011-213392 OAH No. 2013050557 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California (Board) of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

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PARTIES

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1. Kimberly Kirchmeyer (Complainant) is the Interim Executive Director of the Board. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

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2. JOSEPH RALPH SICIGNANO, M.D. (Respondent) is represented in this proceeding by attorney James Victor Kosnett, whose address is: 11355 West Olympic Blvd., Suite 300, Los Angeles, CA 90064.

3. On or about August 9, 1971, the Board issued Physician's and Surgeon's Certificate No. G 21095 to JOSEPH RALPH SICIGNANO, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 05-2011-213392 and will expire on May 31, 2015, unless renewed.

JURISDICTION

4. Accusation No. 05-2011-213392 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 30, 2013. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 05-2011-213392 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 05-2011-213392. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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.

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

CULPABILITY

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

11. Respondent agrees that if he ever petitions for early termination of probation or modification of probation, or if the board ever petitions for revocation of probation, all of the charges and allegations contained in the Accusation No. 05-20110213392 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 21095 issued to Respondent JOSEPH RALPH SICIGNANO, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

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

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

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test

1 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
2 hours of CME of which 40 hours were in satisfaction of this condition.

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

14 A prescribing practices course taken after the acts that gave rise to the charges in the
15 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
16 or its designee, be accepted towards the fulfillment of this condition if the course would have
17 been approved by the Board or its designee had the course been taken after the effective date of
18 this Decision.

19 Respondent shall submit a certification of successful completion to the Board or its
20 designee not later than 15 calendar days after successfully completing the course, or not later than
21 15 calendar days after the effective date of the Decision, whichever is later.

22 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
23 date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to
24 the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education
25 Program, University of California, San Diego School of Medicine (Program), approved in
26 advance by the Board or its designee. Respondent shall provide the program with any information
27 and documents that the Program may deem pertinent. Respondent shall participate in and
28 successfully complete the classroom component of the course not later than six (6) months after

Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

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

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

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being

so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent has successfully completed the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

7. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees

with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly

chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. PROHIBITED PRACTICE. During probation, Respondent is prohibited from prescribing Schedule II, III and IV drugs, except that Respondent is allowed to prescribe the following six (6) drugs: 1) Adderall, 2) Ritalin, 3) Provigi, 4) Klonopin, 5) Xanax, and 6) Ativan. Also each of these drugs shall not be prescribed to any one patient more frequently than every 30 days. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from prescribing as described above. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent shall be prohibited from prescribing any controlled substance until all of the courses and programs listed in this stipulation have been completed.

Respondent shall not practice pain management.

Respondents practice shall be limited to psychiatry.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

10. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

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

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

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

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

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

Address Changes

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

Place of Practice

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

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License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

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

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

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which

may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

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

DATED: 9/20/13

JOSEPH RALPH SICIGNANO, M.D.
Respondent

I have read and fully discussed with Respondent JOSEPH RALPH SICIGNANO, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9-20-13

JAMES VICTOR KOSNETT, ESQ
Attorney for Respondent

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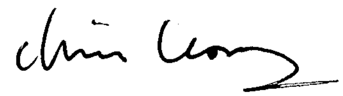
ENDORSEMENT

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

Dated: 9/20/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General



CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 05-2011-213392

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 30, 2013
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **JOSEPH RALPH SICIGNANO, M.D.,** 5233 Elvira Road Woodland Hills, California 91364 Physician's and Surgeon's Certificate No. G 21095 Respondent.	Case No. 05-2011-213392 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 9, 1971, the Board issued Physician's and Surgeon's Certificate No. G 21095 to Joseph Ralph Sicignano, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and, unless renewed, expires on May 31, 2015.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following sections of the Business and Professions Code (Code), Government Code, and Health and Safety Code.

4. Section 11529 of the Government Code states, in pertinent part:

"(a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

" . . .

5. Section 2004 of the Code states:

"The Board shall have the responsibility for the following:

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

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

"(c) Carrying out disciplinary actions appropriate to findings made by a medical quality review committee, the division,[1] or an administrative law judge.

[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 (continued...)

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

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

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

"(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 may, in accordance with the provisions of this chapter:

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

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

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

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper."

7. Section 2234 of the Code, states:

"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.

"(b) Gross negligence.

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Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

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

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

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

"(d) Incompetence.

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

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

8. Section 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.

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"(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.

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

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

10. Section 725 of the Code states:

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

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars

($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

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

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

11. Section 2241 of the Code states:

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

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

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

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

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

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

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

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

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

12. Section 2241.5 (a) of the Code states:

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

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

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

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

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

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

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

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. §§ 801, et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

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

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

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

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

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INTRODUCTION

13. This Accusation involves prescriptions for medications regulated by the Comprehensive Drug Abuse Prevention and Control Act, passed into law in 1970. Title II of this law, the Controlled Substances Act, is the legal foundation of narcotics enforcement in the United States. The Controlled Substances Act regulates the manufacture, possession, movement, and distribution of drugs in our country. The Controlled Substances Act places all drugs into one of five schedules, or classifications, and is controlled by the Department of Justice and the Department of Health and Human Services, including the Federal Drug Administration. In 1972, California followed the federal lead by adopting the Uniform Controlled Substance Act. (Government Code §11153 et seq.).

14. The following delineates the five schedules with examples of drugs, medications, and information about each.

15. **Schedule I Drugs**

These drugs have NO safe, accepted medical use in the United States. This schedule includes drugs such as marijuana, heroin, ecstasy, LSD, and crack cocaine. Schedule I drugs have a high tendency for abuse and have no accepted medical use. Pharmacies do not sell Schedule I drugs, and they are not available with a prescription by physician.

16. **Schedule II Drugs**

Schedule II drugs have a high tendency for abuse, may have an accepted medical use, and can produce dependency or addiction with chronic use. Of all legal prescription medications, Schedule II controlled substances have the highest abuse potential. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs. Examples of Schedule II drugs include cocaine, opium, morphine, fentanyl, amphetamines, and methamphetamines.

Schedule II drugs may be available with a prescription by a physician, but not all pharmacies may carry them. These drugs require more stringent records and storage procedures than drugs in Schedules III and IV.

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17. **Schedule III Drugs**

Schedule III drugs have less potential for abuse or addiction than drugs in the first two schedules and have a currently accepted medical use. The abuse of Schedule III drugs may lead to moderate to high psychological dependence.

Examples of Schedule III drugs include codeine, hydrocodone with acetaminophen, or anabolic steroids. Schedule III drugs may be available with a prescription, but not all pharmacies may carry them.

18. **Schedule IV Drugs**

Schedule IV drugs have a low potential for abuse that leads only to limited physical dependence or psychological dependence relative to drugs in Schedule III. Schedule IV drugs have a currently accepted medical use and have limited addictive properties. Schedule IV drugs have the same restrictions as Schedule III drugs.

Examples of Schedule IV drugs include xanax, valium, phenobarbital, and rohypnol (commonly known as the "date rape" drug). These drugs may be available with a prescription, but not all pharmacies may carry them.

19. **Schedule V Drugs**

Schedule V drugs have a lower chance of abuse than Schedule IV drugs, have a currently accepted medical use in the United States, and lesser chance of dependence compared to Schedule IV drugs. This schedule includes such drugs as cough suppressants with codeine.

Schedule V drugs are regulated but generally do not require a prescription.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

20. **Xanax**, is a dangerous drug pursuant to Code section 4022. It is a Schedule IV Controlled Substance as designated by Health and Safety Code section 11057, subdivision (d)(1). Its generic name is Alprazolam and is used to relieve anxiety.

21. **Norco**, a brand name for hydrocodone with acetaminophen, is a dangerous drug pursuant to section 4022. It is a Schedule II controlled substance as designated by Health and Safety Code section 10055, subdivision (b)(1)(I).

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22. **Vicodin**, is dangerous drug pursuant to section 4022 of the Code. It is a Schedule III controlled substance, as designated by Health and Safety Code section 1056, subdivision (e)(4).

23. **Soma** is a dangerous drug pursuant to section 4022 of the Code. It is not a controlled substance. Its generic name is Carisprodol and it is used as a skeletal muscle relaxant.

24. **Lorazepam (Ativan)** is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(16).

25. **Oxycontin** (oxycodone) is an opioid, i.e., a synthetic narcotic that resembles the naturally occurring opiates. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (b)(1)(M),and a close relative of morphine, heroin, codeine, fentanyl, and methadone.

26. **Hydrocodone/APAP** is an analgesic combination of a narcotic, Hydrocodone, and Acetaminophen. Acetaminophen, often abbreviated as APAP, is a peripherally acting analgesic agent found in many combination products and also available by itself. This combination product is used treat moderate to moderately severe pain. In the U.S., formulations containing more than 15 mg hydrocodone per dosage unit are considered Schedule II drugs. Those containing less than or equal to 15 mg per dosage unit in combination with acetaminophen or another non-controlled drug are called hydrocodone compounds and are considered Schedule III drugs. Hydrocodone is not available in pure form in the United States due to a separate regulation. Hydrocodone is always sold combined with another drug.

27. **Clonazepam (Klonopin)** is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(7). It is used in both the prophylaxis and treatment of various seizure disorders. The dosage of Clonazepam should be carefully and slowly adjusted to meet the needs and requirements of the individual. An initial adult dose, however, should not exceed 1.5 mg daily. Adult maintenance dosage should generally not exceed 20 mg daily.

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28. **Amphetamine** is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (d)(1).

BACKGROUND

29. On March 29, 2013, an ex parte request for immediate issuance of an interim Order of Suspension was granted in part, pursuant to Government Code section 11529 in this matter.

30. On April 22, 2013, a noticed request for immediate issuance of an interim Order of Suspension was granted in part, pursuant to Government Code section 11529 in this matter.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

Patient E.R.[2]

32. On September 15, 2006, 39 year-old female patient E.R. entered treatment with Respondent for depression with affective variability, obsessional worries, marital discord, and severe back pain. E.R. saw Respondent for one hour sessions about 36 times until she died on January 8, 2009. During the time she was under treatment with Respondent, E.R. had at least one TIA (transient ischemic attack or stroke-like symptoms), and underwent the repair of an atrial septal defect (hole in the wall of the heart's upper chambers). She also suffered from a congenital abnormality of the lumbosacral region known as Bertolotti's Syndrome resulting in L5 nerve root pain. Although E.R. had chronic pain problems, an atrial septal repair, a TIA resulting in transient monocular blindness, and multiple epidurals, there was no indication in the records

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[2]The names of patients are kept confidential to protect their privacy rights, and, though known to Respondent, will be revealed to him upon receipt of a timely request for discovery.

that Respondent consulted or conferred with any of the multiple physicians who were treating E.R.

33. Respondent initially treated E.R. for Bipolar II disorder with 200 mg. twice daily of lamotrigine, an anti-convulsant, with little notation of its efficacy. Respondent labeled E.R. as a "rapid metabolizer" without checking her blood plasma levels for the medications he prescribed against the doses she was taking. Respondent also diagnosed E.R. with obsessive compulsive disorder, although his notes indicate the patient's concerns were ruminations rather than obsessions or compulsions.

34. Respondent had no background, training, knowledge, or expertise in the field of pain management or addiction. With no indication, explanation or documentation in the medical records, Respondent changed his treatment of E.R. from psychiatric to virtually pure pain management. Respondent did not perform a medical examination of the patient. Respondent did not develop a treatment plan, provide the patient with informed consent, and did not document periodic chart reviews. In 2008, he began to prescribe Norco. Although E.R. was bipolar, with chronic back pain, and a family history of alcohol abuse, Respondent did not recognize the patient's propensity for a substance abuse problem. In February 2008, Respondent prescribed Norco 10 mg. #360 per month. Respondent determined this was not strong enough for the patient, and in May 2008, he changed her prescription to Oxycontin (a narcotic pain reliever) 10 mg. #360 per month, while simultaneously prescribing Xanax 1.0 mg #120 per month (equivalent to 4 mg. per day), and he added the muscle relaxant Soma 350 mg. approximately 3 per day. When the patient complained of feeling over sedated, Respondent added Adderall XR (an amphetamine) 90 mg. per day. Respondent's notes indicated that the addition of Adderall would enhance the analgesic effect of Oxycontin.

35. Although the patient requested early prescriptions, ran out of her medications, and gave other indications of abusing her medications, Respondent did not consider this to be a potential problem, and continued to prescribe high doses of narcotics, muscle relaxants, and anxiolytics. Respondent created a severe opiate dependency in the patient. Respondent increased the patient's narcotics and muscle relaxants based on her subjective reports

of her status rather than on objective findings. Respondent did not consult with a pain management specialist. He did not coordinate her treatment with her other physicians. He did not check a CURES[3] report or obtain any history to determine whether the patient was seeking medications from other physicians. The combination of drugs Respondent prescribed created a situation for a potential drug overdose.

36. Respondent's notes are a narrative of his thoughts and feelings about the session with the patient, and his thoughts about orthopedic and pain management procedures which had no clear foundation. His notes did not provide an objective measurement of the patient's mental state. Respondent's records did not describe plans of current treatment, the efficacy of the treatments, or consideration of alternative treatments.

37. Respondent prescribed the following drugs, among others, to patient E.R. from January 2008 until her death in January 2009.

(1) Norco 325-10 mg, #360 on January 3, 2008, February 4, 2008, March 12, 2008, April 7, 2008, April 30, 2008, May 20, 2008, June 14, 2008, July 6, 2008, August 5, 2008, August 29, 2008, September 28, 2008, and December 22, 2008.

(2) Oxycodone-APAP 10-325, #360 on January 22, 2008, February 25, 2008, March 26, 2008; April 17, 2008, May 9, 2008, May 31, 2008, June 25, 2008, July 23, 2008, August 21, 2008, and December 8, 2008.

(3) Oxycontin 40 mg, #90 on September 16, 2008; Oxycontin 80 mg, #90 on October 9, 2008, Oxycontin 80 mg, #90 on November 6, 2008; and Oxycontin 80 mg, #20 on January 7, 2009.

(4) Alprazolam (Xanax) 1 mg, #120 on January 23, 2008, March 11, 2008, May 19, 2008, July 5, 2008, September 17, 2008, October 23, 2008, November 20, 2008, December 12, 2008, and January 7, 2009.

[3] C.U.R.E.S, California's database known as the Controlled Substance Utilization Review and Evaluation System, contains over 100 million entries of controlled substance drugs dispensed in California. CURES has launched a real-time access Prescription Drug Monitoring Program (PDMP) system which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access real-time patient controlled substance history information.

(5) Carisoprodol (Soma) 350 mg, #240 on January 16, 2008, January 22, 2008, February 13, 2008, February 25, 2008, March 12, 2008, March 24, 2008, April 3, 2008, April 15, 2008, April 26, 2008, May 7, 2008, May 20, 2008, May 29, 2008, June 14, 2008, June 25, 2008, July 6, 2008, July 22, 2008, August 5, 2008, August 16, 2008, August 29, 2008, September 16, 2008, September 28, 2008, October 9, 2008, October 26, 2008, November 11, 2008, December 9, 2008, December 22, 2008, and January 7, 2009.

(6) Adderall XR 30 mg, #60 on October 9, 2008; Adderall XR 30 mg, #90 on November 6, 2008, and December 10, 2008; and Adderall XR 30 mg, #120 on January 7, 2009.

38. On January 8, 2009, E.R.'s husband found her dead on the floor. The coroner's report indicated that she had lethal levels of multiple substances in her system including Alprazolam, Xanax, Oxycontin, and Soma.

39. On March 27, 2009, a Forensic Science Laboratories, Laboratory Analysis Summary report was done on patient E.R. The contents of her blood included: Oxycodone 2.0 ugml. and high levels of Alprazolam and Amphetamine.

40. Respondent was grossly negligent in the care and treatment of Patient E.R. by the following acts or omissions, separately and together:

(1) He prescribed controlled substances for the patient's chronic back pain without an appropriate medical examination and medical indication.

(2) He failed to develop a treatment plan for pain management, to provide the patient with informed consent, and to document periodic chart reviews.

(3) He failed to consult with any of the multiple physicians who were treating E.R., or refer her to a pain management specialist.

(4) He failed to appropriately use controlled substances in a manner that would not endanger the patient.

(5) Although E.R. was bipolar, with chronic back pain, and a family history of alcohol abuse, he failed to recognize the patient's propensity for a substance abuse problem.

(6) He created a severe opiate dependency by progressively increasing the patient's dependence on Vicodin and Oxycontin.

(7) By prescribing Vicodin, Oxycontin, super therapeutic doses of Adderall, Xanax, and Soma, he created a situation for a drug overdose.

(8) He practiced outside his area of expertise when he took over pain management for which he did not have the expertise, skills, training or knowledge.

Patient K.H.

41. In July 1986, a 35 year-old female, patient K.H., entered treatment with Respondent. She continued seeing Respondent for over 24 years until her death on February 27, 2011. Respondent initially diagnosed K.H. with depression, panic disorder with agoraphobia, obsessive compulsive disorder, social phobia, and bulimia. Respondent provided very little documentation in the records to support these diagnoses. In addition, he diagnosed K.H. with intermittent prescription drug abuse with benzodiazepines, abuse of hydrocodone and Seroquel, and histrionic, dependent, and avoidant personality disorders. There was very little documentation in the record to support these additional diagnoses. Respondent did not perform a medical examination of the patient. Respondent did not develop a treatment plan, provide the patient with informed consent, and did not document periodic chart reviews.

Background

42. In 1986, Respondent initially treated K.H. with 1.0 mg Xanax which he increased to 4 mg per day. This continued for 10 years until about 1996. Respondent attempted to try alternative medications to Xanax, which the patient claimed were intolerable and/or ineffective. By December 1993, the patient became dependent on Xanax, and was taking 6 mg per day. By February 1996, K.H. developed back pain problems, and Respondent prescribed 10/325 Vicodin. In 1997, Respondent changed her prescription to 14 mg per day of Klonopin (benzodiazepine used for treatment of anxiety). In June 1997, when the patient complained of migraines, Respondent prescribed #30 Vicodin with no neurologic work up. By 1998, K.H. was receiving prescriptions for narcotics from other physicians, and her family placed her in a substance abuse/detox program. In 1999, Respondent was aware that K.H. was abusing Klonopin

1 (up to 20 mg. per day), and he attempted to titrate her dose down. However, he was still
2 prescribing large amounts of Klonopin #240 2 mg. In November 2000, Respondent prescribed 16
3 mg. Klonopin, and he added 200 mg. Seroquel (an antipsychotic medication), and 60 mg.
4 Remeron (an antidepressant).

5 43. In September 2009, Respondent engaged K.H.'s husband to monitor and
6 dispense her medications. This plan proved to be a failure. The patient was overusing Klonopin
7 and Seroquel. In 2010, Respondent attempted to switch the patient's medication to Abilify (an
8 antipsychotic), which she rejected. The patient remained on Seroquel. Respondent provided her
9 with a prescription of Klonopin that had 6 refills. K.H. was taking 1000 mg. of Seroquel per day,
10 and her weight was quite high. The patient had developed a true metabolic syndrome as a
11 function of the Seroquel. Respondent identified the patient as a rapid metabolizer. Respondent
12 was not able to differentiate between a patient who developed progressive tachyphylaxis
13 (decrease in response to a dose after repetitive administration of a substance) to certain
14 medications versus a patient who was a true rapid metabolizer.

15 44. Respondent prescribed the following drugs, among others, to patient K.H.
16 from January 2010 until her death in February 2011.

17 (1) Clonazepam 2mg, #84 on January 7, 2010, January 21, 2010, February 3, 2010,
18 February 17, 2010, March 2, 2010, March 16, 2010, March 30, 2010, April 13,
19 2010, April 24, 2010; and Clonazepam 2mg, #126 on May 10, 2010, May 30,
20 2010, June 18, 2010, July 9, 2010, July 29, 2010, August 18, 2010, September 8,
21 2010, September 27, 2010, October 14, 2010, October 31, 2010, November 16,
22 2010, December 3, 2010, December 27, 2010, January 12, 2011, January 30,
23 2011, and February 21, 2011.

24 (2) Seroquel 100 mg, #140 on January 9, 2010, January 21, 2010, February 3, 2010,
25 February 13, 2010, March 1, 2010, March 18, 2010, March 28, 2010, April 14,
26 2010, May 10, 2010, May 25, 2010, June 10, 2010; and Seroquel 100 mg, #210
27 on June 28, 2010, July 21, 2010, August 10, 2010, August 29, 2010, September
28 17, 2010, October 3, 2010, October 16, 2010, November 1, 2010, November 17,

2010, December 3, 2010, December 19, 2010, January 4, 2011, January 20, 2011, February 8, 2011, and February 26, 2011.

45. Specifically, on February 14, 2011, the patient was dispensed drugs from a prescription from Respondent for Norco, 325 mg - 10 mg, quantity 20. On February 21, 2011, the patient was dispensed drugs from a prescription from Respondent for Clonazepam, 2 mg, quantity 106. On February 21, 2011, the patient was dispensed drugs from another prescription from Respondent for Clonazepam, 2 mg, quantity 20.

46. On February 27, 2011, the patient died in her sleep. The cause of death was hypertensive heart disease.

47. On February 28, 2011, an autopsy was performed. A toxicology report issued on March 31, 2011, showed positive findings from matrix source blood including: Clonazepam result 8.4 ng/mL; and 7—Amino Clonazepam 150 ng/mL.

48. In or around September 2009 and following, Respondent was grossly negligent in the care and treatment of Patient K.H. by the following acts or omissions, separately and together:

(1) He prescribed controlled substances without an appropriate medical examination and medical indication.

(2) He failed to develop a treatment plan, to provide the patient with informed consent, and to document periodic chart reviews.

(3) He failed to properly prescribe benzodiazepines.

(4) He failed to recognize the patient's pattern of substance abuse. He failed to recognize that the patient showed the classic pattern of dose escalation of the dependency forming substances Xanax and then Klonopin when she rejected all other antidepressants and anxiolytics that Respondent attempted to put her on, and came back to needing escalating doses of benzodiazepines.

(5) He contributed to a serious dependency in the patient by prescribing escalating doses of Xanax and then Klonopin year after year until it reached 16 mg., and Seroquel up to 1000 mg.

(6) He failed to adequately control the patient's overuse of controlled substances.

(7) He failed to consult with any other physicians, or refer the patient to concurrent psychotherapy, to deal with her anxiety in a nonpharmacologic manner.

Patient R.S.

49. On January 15, 2007, 50 year-old male patient R.S. had an initial visit with Respondent. Previously, R.S. had been on maintenance injections of testosterone cyprionate for ten years with the diagnosis of hypogonadism (low levels of the hormone testosterone). Respondent did not perform a medical examination of R.S. He took the patient's history, and took the patient's word that without replacement therapy, he became irritable, socially withdrawn, and demanding. Without providing any indication in the record, Respondent began prescribing testosterone cyprionate 200 mg. Q7 days by injection. Respondent did not confer with any of the patient's physicians or confirm the history of hypogonadism. There was no documentation in the record that Respondent ever checked the patient's PSA (prostate-specific antigen), performed a prostate examination, or asked the patient if he was using high levels of testosterone to enhance his bicycling performance. Respondent did not develop a treatment plan, provide the patient with informed consent, document periodic chart reviews, or consult with the patient's other physicians. Respondent engaged in the practice of endocrinology without the medical knowledge, training or skill to support this practice. His use of testosterone cyprionate exceeded the usual and customary dose for this agent. Respondent did not consider the possibility of testicular atrophy, prostatic enlargement, the risk of prostatic cancer, or other problems related to the use of androgenic steroids.

50. Shortly into his treatment, when the patient complained of depression, Respondent prescribed the antidepressant Sertraline 50 mg. In 2008, Respondent treated the patient's depression with Effexor XR 150 mg., Abilify 5 mg., and Trazadone for sleep.

51. In 2010, when the patient had dental surgery, Respondent prescribed Norco 10/325 for pain, although the patient's dentist advised him to take Advil. On August 16, 2010, the patient contacted Respondent and said he had acute back strain. Respondent again

prescribed Norco 10/325. Respondent's progress notes indicate that on August 30, 2010, he discussed with the patient the success rate of back surgery.

52. On December 28, 2010, the patient underwent lumbar spine surgery at Kaiser. The Kaiser physicians prescribed methylprednisolone (a corticosteroid), and hydrocodone (an opiate) 10/325 #100 to be used every four hours as needed for pain. In January 2011, the patient requested Respondent provide post-surgical pain management. Respondent became involved in an ongoing process of evaluating the patient based on his reported pain level with and without medication, self-reports of functional impairment, self-reports of lifting and standing capacity, and duration of walking. Although Kaiser was prescribing hydrocodone to R.S., Respondent prescribed Oxycontin 40 mg. twice a day. Respondent did not have knowledge, skill or training in pain management. Seven weeks post surgery, when the patient complained of intolerable pain, Respondent maintained him on Oxycontin 20 mg. twice a day, and also advised him about his post surgical prognosis. Five months post surgery, Respondent prescribed 10 mg Oxycodone 6 per day, to which he added carisprodol (Soma) 350 mg. twice a day, and also Cymbalta as an analgesic. He suggested the patient receive physical therapy at Kaiser. Six months post operatively, Respondent continued the patient on this pain medicine regimen without performing a physical examination, seeking a consultation, or verifying the disability other than through the patient's self-report. He then escalated the patient's oxycodone, and prescribed 8 per day. Respondent deviated from his treatment plan only when the patient informed him that he was the subject of a Medical Board investigation.

53. Respondent prescribed the following drugs, among others, to patient R.S. from December 12, 2010, through August 26, 2011.

(1) Testosterone 200 mg/ml on December 12, 2010, March 10, 2011, May 8, 2011, June 29, 2011, and August 22, 2011.

(2) Oxycontin 40 mg #45 on January 10, 2011; Oxycontin 40 mg #40 on February 7, 2011; and Oxycontin 20 mg #45 on February 22, 2011.

(3) APAP/Oxycodone 325-10 mg #60 on March 7, 2011; #80 on March 21, 2011, and April 11, 2011; #90 on April 26, 2011, and May 9, 2011; #60 on May 20, 2011; #180 on June

3, 2011; #90 on June 24, 2011, and July 5, 2011; #84 on July 15, 2011; and #90 on August 12, 2011, and August 26, 2011.

54. Respondent was grossly negligent in the care and treatment of Patient R.S. by the following acts or omissions, separately and together:

(1) He prescribed controlled substances without an appropriate medical examination and medical indication.

(2) He failed to develop a treatment plan, to provide the patient with informed consent, and to document periodic chart reviews.

(3) When Respondent provided the patient with testosterone injections, he practiced outside his area of medical expertise.

(4) His use of testosterone cyprionate exceeded the usual and customary dose, and was potentially harmful.

(5) He failed to consider the possibility of testicular atrophy, prostatic enlargement, the risk of prostatic cancer, or other problems related to the use of androgenic steroids.

(6) He failed to consult with the patient's primary care physician or any specialty physicians.

(7) He provided R.S. with high potency narcotics without having the appropriate medical knowledge, training or skill in pain management.

(8) He contributed to the patient's development of an opiate dependency.

(9) He offered the patient his opinions regarding surgical outcomes of lumbosacral procedures which was outside his area of medical expertise.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of three patients. The facts and circumstances alleged above are incorporated here as if fully set forth.

Patient E.R.

56. Respondent was repeatedly negligent in the care and treatment of Patient E.R. by the following acts or omissions, separately and together.

(1) He failed to maintain adequate and accurate medical records.

(2) He failed to maintain records regarding the patient's progress with regard to her treatment with pain medications, and her response to the pain medications.

(3) His notes failed to objectively measure the patient's mental state.

(4) He prescribed controlled substances for the patient's chronic back pain without an appropriate physical examination and medical indication.

(5) He failed to develop a treatment plan for pain management, to provide the patient with informed consent, and to document periodic chart reviews.

(6) He failed to consult with any of the multiple physicians who were treating E.R., or refer her to a pain management specialist.

(7) He failed to appropriately use controlled substances in a manner that would not endanger the patient.

(8) Although E.R. was bipolar, with chronic back pain, and a family history of alcohol abuse, he failed to recognize the patient's propensity for a substance abuse problem.

(9) He created a severe opiate dependency by progressively increasing the patient's dependence on Vicodin and Oxycontin.

(10) By prescribing Vicodin, Oxycontin, super therapeutic doses of Adderall, Xanax, and Soma, he created a situation for a drug overdose.

(11) He practiced outside his area of expertise when he took over the pain management of the patient.

(12) He did not have the expertise, skills, training or knowledge of pain management.

Patient K.H.

57. Respondent was repeatedly negligent in the care and treatment of Patient K.H. by the following acts or omissions, separately and together.

(1) He failed to maintain adequate and accurate medical records.

(2) His documentation did not support his diagnoses.

(3) He prescribed controlled substances without an appropriate medical examination and medical indication.

(4) He failed to develop a treatment plan, to provide the patient with informed consent, and to document periodic chart reviews.

(5) He failed to properly prescribe benzodiazepines.

(6) He failed to recognize the patient's pattern of substance abuse. He failed to recognize that the patient showed the classic pattern of dose escalation of the dependency forming substances Xanax and then Klonopin when she rejected all other antidepressants and anxiolytics that Respondent attempted to put her on, and came back to needing escalating doses of benzodiazepines.

(7) He contributed to a serious dependency in the patient by prescribing escalating doses of Xanax and then Klonopin year after year until it reached 16 mg., and Seroquel up to 1000 mg.

(8) He failed to adequately control the patient's overuse of controlled substances.

(9) He failed to consult with any other physicians, or refer the patient to concurrent psychotherapy, to deal with her anxiety in a nonpharmacologic manner.

Patient R.S.

58. Respondent was repeatedly negligent in the care and treatment of Patient R.S. by the following acts or omissions, separately and together:

(1) He failed to maintain adequate and accurate medical records.

(2) He prescribed controlled substances without an appropriate medical examination and medical indication.

(3) He failed to develop a treatment plan, to provide the patient with informed consent, and to document periodic chart reviews.

(4) When Respondent provided the patient with testosterone injections, he practiced outside his area of medical expertise.

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(5) His use of testosterone cyprionate exceeded the usual and customary dose, and was potentially harmful.

(6) He failed to consider the possibility of testicular atrophy, prostatic enlargement, the risk of prostatic cancer, or other problems related to the use of androgenic steroids.

(7) He failed to consult with the patient's primary care physician or any specialty physicians.

(8) He provided R.S. with high potency narcotics without having the appropriate medical knowledge, training or skill in pain management.

(9) He contributed to the patient's development of an opiate dependency.

(10) He offered the patient his opinions regarding surgical outcomes of lumbosacral procedures which was outside his area of medical expertise.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

59. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that he was incompetent in the care and treatment of Patients E.R., K.H., and R.S. The facts and circumstances alleged above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

60. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients E.R., K.H., and R.S. The fact and circumstances alleged above are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

61. Respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct in care and treatment of Patients E.R., K.H., and R.S. The facts and circumstances alleged above are incorporated here as if fully set forth.

PRAYER

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

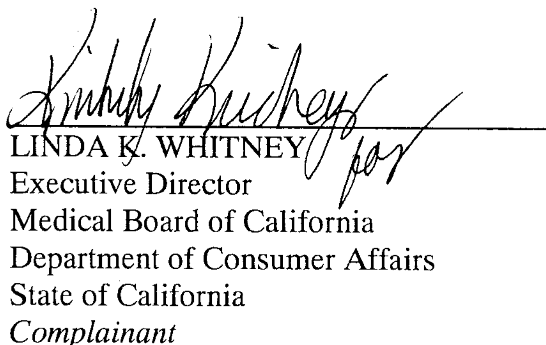
1. Revoking or suspending Physician's and Surgeon's Certificate Number G21095, issued to Joseph Ralph Sicignano, M.D.;

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

3. Ordering him to pay the Medical Board of California, if placed on probation, the cost of probation monitoring; and

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

DATED: April 30, 2013



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

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