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

In the Matter of the Accusation Against: **Nathan H. Thuma, M.D.** 1030 Main Street Suite 210 St. Helena, CA 94574 Physician's and Surgeon's Certificate No. G58451, Respondent.	Case No. 800-2014-008551 **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 (Board).

2. On or about August 25, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G58451 to Nathan H. Thuma, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

3. During all times alleged herein, Respondent was board-certified as a psychiatrist and as a DEA-approved prescriber of buprenorphine.

JURISDICTION

4. 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.

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

6. 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.

"(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.

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

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

7. Section 2242 of the Code states, in pertinent part:

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

8. 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."

9. 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.

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"(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."

PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS

10. Abilify, a trade name for aripiprazole, is an anti-psychotic medication that is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It may also be used together with other medications to treat major depressive disorder in adults. It is a dangerous drug as defined in Business and Professions Code section 4022. Taking Abilify with other drugs that induce sleepiness may worsen the effect.

11. Adderall, a trade name for amphetamine and dextroamphetamine, is a central nervous system stimulant indicated for use in the treatment of Attention Deficit Hyperactivity Disorder (ADHD) and narcolepsy. It is a Schedule II controlled substance as defined by section 11055 (d)(1) of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations and is a dangerous drug as defined in Business and Professions Code section 4022.

12. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a Schedule IV controlled substance as defined by section 11057(d)(32) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. It is a central nervous system (CNS) depressant that is indicated for the short-term treatment of insomnia.

13. Ativan, a trade name for lorazepam, is a benzodiazepine and central nervous system (CNS) depressant used in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Long-term or excessive use of Ativan can cause dependency. Concomitant use of alcohol or other CNS depressants may have an additive effect.

14. Dexedrine, a trade name for dextroamphetamine sulfate, is a central nervous system stimulant. It is used to treat Attention Deficit Hyperactivity Disorder (ADHD) and to treat narcolepsy. It is a Schedule II controlled substance as defined by section 11055(d) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

15. Dilaudid, a trade name for hydromorphone hydrochloride, is a hydrogenated ketone of morphine and an opioid analgesic whose principal therapeutic use is for relief of pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

16. Endocet is a trade name for the combination of oxycodone and acetaminophen. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

17. Fentanyl is an opioid analgesic which can be administered by an injection, through a transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form (known as Fentora). It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. It is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and that requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. When patients are receiving fentanyl, the dosage of central nervous system depressant drugs should be reduced. Use of fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

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18. Fioricet is the trade name for the combination of butalbital (a barbiturate), acetaminophen, and caffeine. It has a sedating effect and is used in the treatment of headaches. It is a dangerous drug as defined in Business and Professions Code section 4022.

19. Geodon is the trade name for ziprasidone hydrochloride. It is an anti-psychotic drug that is used in the treatment of schizophrenia and of the manic symptoms of bipolar disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

20. Hydrocodone bitartrate with acetaminophen, known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. It is indicated for the relief of moderate to severe acute and chronic pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and is a Schedule II controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations[1] and is a dangerous drug as defined in Business and Professions Code section 4022.

21. Klonopin, a trade name for clonazepam, is an anti-convulsant of the benzodiazepine class of drugs. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(7) and is a dangerous drug as defined in Business and Professions Code section 4022. It produces CNS depression and should be used with caution with other CNS depressant drugs.

22. Morphine Sulfate, known by the trade name MS Contin, is an opioid pain medication indicated for the management of moderate to severe acute and chronic pain. Morphine is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

23. OxyContin and Oxycodone IR are both trade names for oxycodone hydrochloride, a pure agonist opioid that is used to treat moderate to severe pain lasting for an extended period of time. It is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of the Health and Safety Code and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations and is a dangerous drug as defined in Business and Professions Code section 4022.

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[1] Effective 10/06/2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

24. Risperdal, a trade name for Risperidone, is an anti-psychotic agent and a benzisoxazole derivative indicated for the management of the manifestations of psychotic disorders. It is a dangerous drug as defined by Business and Professions Code section 4022.

25. Ritalin, a trade name for methylphenidate hydrochloride, is a central nervous system stimulant. It is indicated for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and narcolepsy. It is a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

26. Seroquel, a trade name for quetiapine, is an anti-psychotic drug indicated for the management of the manifestations of psychotic disorders, such as schizophrenia and bipolar disorder. It may be used in conjunction with anti-depressant medications to treat major depressive disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

27. Suboxone (Buprenorphine and naloxone) and Subutex (Buprenorphine) are both trade names for drugs containing buprenorphine, an opioid (narcotic) partial agonist-antagonist that works by binding receptors in the brain and nervous system to help prevent withdrawal symptoms in someone who has stopped taking narcotics (e.g., heroin, oxycodone). Buprenorphine is used as part of an office-based opiate maintenance treatment. It is a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Under the Drug Addiction Treatment Act (DATA) codified at 21 U.S.C. 823(g), prescription use of Suboxone in the treatment of opioid dependence is limited to physicians who meet certain qualifying requirements, who have notified the Secretary of Health and Human Services (HHS) of their intent to prescribe this product for the treatment of opioid dependence, and who have been assigned a unique identification number that must be included on every prescription.

28. Tylenol with Codeine No. 3 and Tylenol with Codeine No. 4 are trade names for acetaminophen with codeine. They contain a combination of 300 mg. of acetaminophen with either 30 mg. (No. 3) or 60 mg. (No. 4) of codeine. It is a combination opioid analgesic that is

used to relieve mild to moderately severe acute and chronic pain. It is a Schedule III controlled substance under Health and Safety Code section 11056 and is a dangerous drug as defined in Business and Professions Code section 4022.

29. Valium, a trade name for diazepam, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the pre-disposition of such patients to habituation and dependence.

30. Vyvanse, a trade name for lisdexamfetamine, is a central nervous system stimulant that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is used to treat Attention Deficit Hyperactivity Disorder (ADHD) and is also used to treat moderate to severe binge eating disorder. It should not be taken in the evening because it may cause sleep problems (insomnia). It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

31. Wellbutrin, a trade name for bupropion, is an anti-depressant medication that is used to treat major depressive disorder and seasonal affective disorder. Drinking alcohol with bupropion may increase the risk of seizures. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

32. Xanax, a trade name for Alprazolam, is used in the management of anxiety and panic disorders. It is a psychotropic triazolo-analogue of the benzodiazepine class of central nervous system-active compounds. It is a Schedule IV controlled substance as defined by section 11057, subdivision (d) of the Health and Safety Code, and by section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code

section 4022. It has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient A[2]: Gross Negligence, Incompetence, Prescribing Without Appropriate Prior Examination and Medical Indication, Excessive Prescribing)

33. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient A constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

34. In or about May 1998, Respondent first saw Patient A for outpatient mental health treatment. At the time, Patient A was a 29-year-old female with a history of sexual abuse as a child, a long history of emotional problems, recurrent depression and psychosis, multiple suicide attempts, and severe alcohol and poly-substance abuse. Patient A reported having just completed a residential drug recovery program. The patient also reported using methamphetamine with her boyfriend.

35. After May 1998, Respondent saw and treated Patient A on a regular basis up until about December 1999. Respondent diagnosed Patient A with severe ADHD, without documenting a full examination and assessment. During the course of Respondent's treatment, the patient's addiction was active with multiple relapses. Respondent prescribed Dexedrine, a controlled substance, along with other prescription drugs, with no clear positive response from the patient regarding the treatment.

36. In or about December 1999, Patient A was hospitalized for four days. Respondent was asked by the patient's outpatient substance abuse program counselor to withdraw from the case so that the patient could see someone closer to home who would not prescribe Dexedrine.

[2] To protect the patients' privacy, they will be referred to by letter designations. Respondent will be provided with the full names of the patients through discovery.

37. On or about January 31, 2006, after an absence of about six years, Patient A returned to see Respondent. The patient reported that for the past three years she was on SSDI and was unable to work because she could not stay sober for more than 90 days. The patient also reported that she was currently taking methadone and Zoloft that was prescribed by a primary care physician. Respondent prescribed Dexedrine to the patient, although the patient had a history of being addicted to Dexedrine.

38. By February 2007, Respondent was prescribing Dexedrine, Geodon, Zoloft, along with two additional benzodiazepine sedatives: Xanax and Klonopin. Respondent was aware that the patient was also getting methadone from another physician for back pain.

39. On or about December 10, 2010, Respondent spoke by telephone with the patient who reported another severe vodka relapse from which she was just recovering. Respondent prescribed the antipsychotic drug Geodon to be given intramuscularly (IM) and faxed a prescription for Geodon IM 20 mg. prn #3 doses plus 11 refills. Respondent noted that the patient liked the idea of Geodon IM because it "reminded her of prior heroin use." Although it is unclear from Respondent's records, it appears that he prescribed Geodon as a take-home medication to be self-injected. Respondent also issued refill prescriptions for Xanax (#90 with 11 refills) and Dexedrine (#210).

40. In or about January 2011, the patient was hospitalized and was in the ICU for alcohol withdrawal, septic shock, lactic acidosis, and acute respiratory failure. The patient had also swallowed a few coins.

41. On or about April 29, 2011, Respondent added Suboxone (buprenorphine) to the prescribing regimen, which included Geodon, Zoloft, Xanax, and Dexedrine.

42. In or about July 2011, the patient was heavily intoxicated, found in her bed lying in her own feces and urine, and was brought to a hospital Emergency Department, placed on an involuntary psychiatric hold, and treated for alcohol withdrawal.

43. During another hospitalization in 2012, the patient's liver function was determined to be poor and it was attributed to alcohol-related hepatitis.

44. During the course of treatment, Respondent was aware that Patient A had been "fired" by a pharmacist, by her pain doctor, and by her substance rehabilitation program due to her multiple relapses and behavior.

45. During the course of treatment, the patient kept relapsing and demonstrated increasingly serious consequences of addiction: increased depression, poor hygiene, bedwetting, sedation, nausea, vomiting, ataxia (trouble with balance), repeated falls, bone fractures, a DUI charge, a motor vehicle accident, withdrawal symptoms, a withdrawal seizure, repeat hospitalizations, one ICU stay, broken ribs, amnesia, and incarceration. Yet, Respondent did not re-evaluate the effectiveness of his treatment. He instead escalated the doses of controlled substances.

46. On April 20, 2013, a neighbor found Patient A dead at home. The Marin County Coroner's report found that the immediate cause of death was acute alcohol intoxication and that the death was an accident. Other causes of death listed were: chronic alcoholism with fibrosis and severe steatosis of the liver, chronic obstructive pulmonary disease. In addition to alcohol, the patient died with controlled substances (benzodiazepines) in her system.

47. Respondent's overall conduct, acts and/or omissions with regard to Patient A, as set forth in paragraphs 33 through 46 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent treated Patient A with controlled substances without ever performing a complete psychiatric history and assessment, including a complete medical, substance abuse, and social history.

b. Respondent failed to document a clear and comprehensive treatment plan and periodic review of the effectiveness of the treatment.

c. Respondent failed to document legitimate medical indications for the prescribing and the escalating of doses of multiple controlled substances for long-term use, particularly to an alcoholic and addict such as Patient A.

d. Respondent demonstrated gross negligence and/or a lack of knowledge in prescribing buprenorphine to Patient A concurrently with sedatives and other controlled substances.

e. Respondent failed to maintain clear and complete progress notes, and failed to maintain a clear and updated list of all of the concurrent psychoactive central nervous system medications that Patient A was taking.

f. Respondent failed to consult with the patient's other medical providers and/or failed to ask for and obtain collateral records. Respondent failed to obtain contemporaneous hospital and rehabilitation center records after the patient had repeated medical hospitalizations and multiple relapses with stays at rehabilitation centers.

g. Respondent failed to document that he obtained informed consent from Patient A for treatment with multiple psychiatric medications, controlled substances. There was no documentation that Respondent discussed the risks, benefits, and possible complications of treatment with psychiatric medications, discussed the risk of treatment vs. no treatment, and the alternatives to psychiatric medicines, and/or discussed the risk of relapse when prescribing multiple controlled substances to an addict.

h. Respondent prescribed controlled substances to an addict without proper consideration and monitoring.

i. Respondent failed to order initial baseline screening lab tests and to conduct follow-up lab tests, or to document why such testing was not needed.

j. Respondent failed to conduct random urine or blood toxicology screenings, especially when the patient admitted to relapsing and/or requested early refills of her prescription medications.

k. Respondent failed to perform a suicide risk assessment on Patient A, initially and whenever there was a clinical change in the patient's condition, e.g. after an overdose, after a relapse, or when the patient reported taking increased quantities of medications.

l. Respondent demonstrated gross negligence and/or a lack of knowledge in prescribing Geodon IM to Patient A for self-injection.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient B: Gross Negligence, Incompetence, Prescribing Without Appropriate Prior Examination and Medical Indication, Excessive Prescribing)

48. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient B constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

49. On or about January 5, 2006, Patient B, a 29-year-old female, began to see Respondent for treatment after she was discharged from a psychiatric hospital. Patient B was an addict and had multiple health problems, including chronic pain. Patient B had a history of being sexually abused as a child by a family member. By the age of fifteen, Patient B was addicted to prescription opiates, poly-substances, and had multiple relapses. The patient had a significant history of impulsivity and self-harm behavior with multiple suicide attempts (overdosing), multiple admissions to drug treatment centers and crisis centers, along with other hospitalizations. In 2003, Patient B spent four months in jail for stealing prescription medications from her mother. The patient had not worked since 2002. She reported that she lost her driver's license four years prior because she had fainted while driving. The patient reported that she was trying to get an appointment to see a pain specialist. Respondent diagnosed Patient B with Bipolar Affective Disorder, Type II, Post-Traumatic Stress Disorder, Borderline Personality Disorder, Opiate Dependence, and mild Autism. Respondent prescribed Haldol, Lamictal, Cogentin, Ambien, and Lorazepam.

50. Respondent did not complete a thorough psychiatric evaluation and history at the time of the initial visit and/or during the course of treatment. A comprehensive list of all the patient's substances of abuse was not documented.

51. Within less than one month after starting treatment, Respondent began to prescribe Subutex (buprenorphine) to the patient.

52. Within months of starting treatment, Respondent began prescribing opiates and sedatives in addition to the buprenorphine, escalating the doses during the course of treatment, without documented medical indications.

53. Starting in or about September 2012, Respondent began to prescribe opiates on a chronic basis for pain, in escalating doses, without documented medical indications.

54. Respondent treated Patient B with multiple controlled substances and other dangerous drugs, including: Tylenol with codeine, Norco/Vicodin, Dilaudid, Fentanyl patches, Morphine sulfate, OxyContin, Buprenorphine (Subutex/Suboxone), Fioricet, Ambien, Xanax, Ativan, Endocet, and Lyrica.

55. During the course of treatment, Patient B missed scheduled appointments and made frequent phone calls to Respondent, not all of which were documented by Respondent. Respondent also would talk on the phone with Patient B in place of an office visit.

56. Patient B frequently requested early refills or increased doses of controlled substances and also frequently reported losing her prescriptions or reported them stolen. Respondent frequently noted that the patient was non-compliant with the medications and did not follow the dosing directions, often taking extra doses. Yet, Respondent granted the patient's requests for early refills and for increased doses, without documenting a medical indication.

57. Respondent continued to prescribe Fentanyl patches for daily use even after the patient reported that she had problems keeping the patch on her arm and that she would instead suck the patch.

58. During the course of treatment, Respondent would call in or fax prescriptions to several different pharmacies or Respondent would mail the prescriptions for controlled substances directly to the patient. Patient B used multiple pharmacies to obtain her prescriptions and would often change the pharmacy.

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59. During the course of treatment, Respondent was aware that Patient B was also being treated by other physicians and was aware that the patient went to the hospital emergency room to get opiate injections.

60. During the course of treatment, Patient B was chronically suicidal and had a history of multiple hospitalizations, cutting and burning herself, and a history of overdosing. The patient also reported physical withdrawal symptoms, multiple falls, and multiple seizures. Respondent documented the following symptoms: auditory hallucinations, insomnia, depression, suicidal ideation, irritability, temper tantrums, visual hallucinations, and nightmares.

61. Respondent's overall conduct, acts and/or omissions, with regard to Patient B, as set forth in paragraphs 48 through 60 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient B as follows:

a. Without ever performing a complete psychiatric history and assessment of the patient, including a complete medical, substance abuse, and social history, Respondent treated the patient with controlled substances and other prescription medications.

b. During the course of treatment of Patient B, Respondent failed to maintain clear and complete progress notes, and failed to maintain a clear and updated list of all of the concurrent psychoactive central nervous system medications that the patient was taking.

c. Respondent did not seek to obtain records from collateral sources. Respondent failed to order collateral hospital records for the patient's repeated medical hospitalizations and emergency room visits.

d. Respondent failed to document a clear and comprehensive treatment plan and failed to document periodic review of the effectiveness of the treatment.

e. Respondent failed to document that he obtained informed consent from the patient with regard to his treatment of multiple controlled substances, that he discussed the risks, benefits

and possible complications of the psychiatric medications, and the alternatives to psychiatric medicines, and/or discussed the risk of relapse when prescribing multiple controlled substances to an addict.

f. Respondent failed to order initial and follow-up lab tests and/or failed to document why testing was not needed.

g. Respondent failed to perform routine and/or random urine or blood toxicology screening for this patient who admitted to relapsing and/or who had requested early refills of prescriptions.

h. Respondent demonstrated gross negligence and/or incompetence in the prescribing of buprenorphine to Patient B.

i. Respondent demonstrated gross negligence and/or incompetence in the prescribing to Patient B of multiple controlled substances (such as Fentanyl, Oxycodone, Hydromorphone, Hydrocodone, Codeine, Ambien, and Lorazepam) at escalating doses and for long term use.

j. Respondent prescribed controlled substances to an addict without proper consideration and monitoring.

k. Respondent's prescribing of opiates, other than buprenorphine, on a chronic basis to Patient B, who was a psychiatric patient, was outside of Respondent's scope of practice and constitutes gross negligence and/or incompetence.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient C: Gross Negligence, Incompetence, Prescribing Without Appropriate Prior Examination and Medical Indication, Excessive Prescribing)

62. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient C constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

63. On or about December 24, 2010, Patient C, a 19-year-old male, saw Respondent to begin treatment for opiate addiction using Suboxone. Patient C had a history of addiction to

opiates and methamphetamines. The patient was living with his parents. His family history included drug and alcohol abuse. He had sold drugs to maintain his habit and had been arrested twice for methamphetamine-related charges. At the time of the initial visit, Patient C reported using 200 mg of OxyContin daily and he stated that he had taken six Vicodin prior to the visit. The patient reported that he was currently in a court-ordered drug rehabilitation program and that he had to switch groups because of a dirty test. Respondent's diagnosis, based on the clinical interview of the patient, was panic disorder, opiate dependence, and anti-social traits. Respondent prescribed #30 Suboxone (buprenorphine). Respondent did not order any urine or blood toxicology screens.

64. Respondent continued to see Patient C approximately every month. At a visit on February 4, 2011, the patient reported running out of Suboxone a few days before. The patient reported that he took the Suboxone "erratically' and that some of it may have been stolen. The patient also asked for Wellbutrin and mentioned that he was starting to have health insurance through Kaiser. Respondent noted in the chart that he prescribed: #60 Suboxone film, #30 Paxil 20 mg., and #30 Wellbutrin XL, plus three refills each for the Paxil and the Wellbutrin XL.

65. On or about April 1, 2011, the patient requested Adderall and Respondent added Adderall to the treatment, prescribing #60 Adderall IR 20 mg. bid.

66. On or about April 29, 2011, Respondent noted that Patient C claimed that he had been without Adderall for the last week because he had left the bottle of pills at his mother's house. Without any documented medical indication, Respondent increased the Adderall prescribed to #80 Adderall 20 mg, to be taken three times a day, and also prescribed #60 Subutex 8 mg., along with Paxil.

67. In the progress note for May 27, 2011, Respondent noted again that the patient was not compliant with his prescription medications. The patient reported that he recently went five days without Adderall and buprenorphine and that he "did okay." Respondent continued to prescribe #60 Adderall IR and #60 Subutex 8 mg., plus one refill for each.

68. For the remainder of 2011, the patient saw Respondent only twice: in July and in November. During that time, the patient reported running out of Adderall and of someone

stealing his buprenorphine. Respondent continued to issue prescriptions, with refills, for Adderall IR and for Subutex (buprenorphine).

69. In or about 2012, Respondent saw the patient about every two or three months. The patient continuously reported running out of Adderall and he claimed that his parents were "dipping into his Adderall." Respondent continued to prescribed Adderall IR and Subutex (buprenorphine) with refills, in addition to other prescription medications.

70. In the progress note for July 6, 2012, Respondent noted that the patient had just turned 21 years of age. The patient stated that he had run out of Adderall awhile back, that he had tried his mother's Abilify and "liked it." Respondent gave the patient samples of Abilify 5 mg. samples and issued prescriptions, with two refills each, for #60 Adderall IR 30 mg. and #60 Buprenorphine 8 mg.

71. On or about January 4, 2013, Respondent noted that the patient said that he quit Adderall a month ago and ran out of Subutex five days ago but was able to get a refill of an old prescription through CVS. Respondent prescribed Xanax and Subutex, with two refills.

72. On or about April 5, 2013, Respondent saw Patient C who reported that his mother gave him Klonopin at times and that he wanted Xanax for chronic social anxiety. The patient reported now getting care from Kaiser. Respondent prescribed #30 Xanax 1 mg. with two refills, along with a #30 Buprenorphine 8 mg. with two refills.

73. On or about May 4, 2013, the patient requested to double the dose of Xanax and Respondent agreed, without documenting a medical indication for the increased dose.

74. On or about August 2, 2013, the patient saw Respondent and reported that he was taking more Subutex than prescribed, 12 mg. daily instead of 8 mg. The patient also said that he was getting Klonopin from his mother to smooth out the Xanax. Respondent also noted that the patient was getting prescriptions for Effexor and Wellbutrin from Kaiser. Respondent prescribed Klonopin (clonazepam) in addition to prescriptions for #60 Xanax 2 mg. and #120 Subutex 8 mg., with refills plus an extra prescription.

75. On or about October 8, 2013, the patient reported that he was using more medications than prescribed, that he was taking too much Xanax and Klonopin, and he admitted that he had

lied to Respondent about having a brother home from prison. Respondent continued to prescribe: #60 Subutex 8 mg., #90 Clonazepam 1 mg., and #90 Tegretol 200 mg., with a refill for each prescription.

76. A week later, on October 15, 2013, the patient made an unannounced visit to Respondent's office. The patient stated that he had run out of Xanax. Respondent issued prescriptions for #90 Xanax 2 mg. with one refill and #90 Seroquel 100 mg. with two refills.

77. During the course of treatment in 2014, Respondent was aware that the patient was not compliant with his prescription medications, that he took more medication than prescribed, and was requesting early refills. Yet, Respondent continued to grant the patient's refill requests and to issue sequential and refill prescriptions.

78. On or about April 1, 2014, Respondent increased the quantities and prescribed #120 Xanax 2 mg. and #120 Clonazepam 2 mg. with one refill. There was no documentation of any medical indication for the increased dosages.

79. On or about September 23, 2014, the patient stopped by Respondent's office for an early refill. Respondent noted that he had called in a refill the day before for #30 Subutex. The patient reported that he was taking 4 mg. each of Xanax and Klonopin in the morning. Respondent also noted that the patient reported that he was going to start attending an outpatient substance abuse program at Kaiser. Respondent wrote in the chart that the patient was an "abject drug addict."

80. Respondent's records for Patient C include a letter dated September 24, 2014 from Kaiser (TPMG) informing him that the patient had entered the Kaiser Chemical Dependency Recovery Program in Vallejo and that the patient was to begin supervised medical detoxification from benzodiazepines.

81. On or about December 23, 2014, Respondent noted that the patient completed the Kaiser Outpatient Chemical Recovery Program and was off all benzodiazepines. The patient reported getting Suboxone from Kaiser but wanted to increase his dose of buprenorphine and wanted to resume taking Adderall. Respondent prescribed: #60 Buprenorphine 8 mg. and #60 Adderall IR 15 mg.

82. On or about April 21, 2015, the patient reported to Respondent that the Medical Board was investigating Respondent. Respondent noted in the patient's chart that "for awhile there he got too many benzos from me."

83. In or about June 2015, the patient reported relapsing on benzodiazepines (Klonopin, Xanax) along with smoking cannabis at night. Respondent prescribed Klonopin in weekly doses for eight weeks and Buprenorphine with two refills.

84. In or about June 2015, Patient C reported that he had relapsed on benzodiazepines. As a result, his mother kicked him out of the home and he was homeless for a period of time.

85. In or about August or September 2015, Respondent saw Patient C, who was living with his grandparents. Respondent noted in the chart that the patient abuses Klonopin even though he is prescribed just enough for one week at a time. The patient also reported smoking marijuana at night. Respondent increased the Klonopin and the Wellbutrin, for which he wrote prescriptions in two different strengths, along with prescriptions for Buprenorphine, Effexor, and Lamictal.

86. During the course of treatment in 2016, Patient C continued to request early refills of both Xanax and Klonopin, which Respondent mostly granted. The patient also was still being prescribed psychiatric medications and was using cannabis.

87. On or about March 15, 2016, Respondent noted that the patient "wants Adderall again." Respondent prescribed Ritalin IR 20 mg., in addition to Buprenorphine and Klonopin. But on March 18, 2016, the patient stopped by Respondent's office and Respondent wrote a prescription for #60 Adderall IR 10 mg. because the patient "dislikes Ritalin." Then on or about April 26, 2016, the patient stated that he preferred Ritalin to Adderall and Respondent prescribed #60 Ritalin 20 mg., along with Klonopin and Buprenorphine.

88. During the course of treatment, Patient C demonstrated multiple behaviors that were indicative of prescription drug misuse.

89. Through at least September 2016, Respondent continued to prescribe to Patient C, on an approximately monthly basis, Clonazepam, Buprenorphine, and Ritalin (methylphenidate hydrochloride).

90. Respondent's overall conduct, acts and/or omissions with regard to Patient C, as set forth in paragraphs 62 through 89 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient C as follows:

a. Without ever performing a complete psychiatric history and assessment of the patient, including a complete medical, substance abuse, and social history, Respondent treated the patient with controlled substances (opiates, sedatives, and stimulants).

b. During the course of treatment of Patient C, Respondent failed to maintain clear and complete progress notes, and failed to maintain a clear and updated list of all of the concurrent psychoactive central nervous system medications that the patient was taking.

c. Respondent did not seek to obtain records from collateral sources. Respondent failed to order collateral records for the patient's treatments with other health care providers.

d. Respondent failed to document a clear and comprehensive treatment plan and failed to document periodic review of the effectiveness of the treatment.

e. Respondent failed to document that he obtained informed consent from Patient C with regard to his treatment of multiple controlled substances, that he discussed the risks, benefits and possible complications of the psychiatric medications and alternatives to the treatment using multiple controlled substances, and/or discussed the risk of relapse when prescribing multiple controlled substances to an addict.

f. Respondent failed to order initial and follow-up lab tests and/or failed to document why testing was not needed.

g. Respondent failed to perform routine and/or random urine or blood toxicology screening for this patient who admitted to relapsing and/or who had requested early refills of prescriptions.

h. Respondent prescribed controlled substances to an addict without proper consideration and monitoring.

i. Respondent demonstrated a lack of knowledge in prescribing buprenorphine and then adding other controlled substances, such as Xanax and/or Klonopin.

j. Respondent prescribed multiple controlled substances for long-term use, and at escalating doses, to an addict without documenting a reasonable medical indication.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient D: Gross Negligence, Incompetence, Prescribing Without Appropriate Prior Examination and Medical Indication, Excessive Prescribing)

91. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient D constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

92. On or about February 13, 2010, Patient D, a 59-year-old male, saw Respondent for opiate maintenance treatment using Suboxone. Patient D had a history of chronic foot pain and was prescription opiate abuse. The patient reported that he was taking OxyContin for peripheral neuropathy pain. He was seeing a primary care physician, a neurologist, and pain management doctor. He had a family history of alcoholism. Respondent prescribed Suboxone (buprenorphine), Cymbalta, and Vyvanse.

93. Within about two weeks of starting the Suboxone, however, the patient aborted the Suboxone treatment. Respondent prescribed Oxycodone IR 80 mg. and increased the dose of Vyvanse.

94. On or about April 23, 2010, Respondent began to prescribe to Patient D both OxyContin ER 80 mg. and Oxycodone IR 15 mg. along with the Vyvanse. There was no documentation of a medical indication for this prescribing in the patient's chart.

95. By July 2010, Respondent's prescribing of opiates had escalated so that the patient was getting monthly about #150 Oxycodone IR 15 mg., #120 OxyContin 80 mg., in addition to

Vyvanse, a stimulant. There was no documentation in the records of medical indications, a treatment plan, periodic review, and/or monitoring.

96. On or about August 17, 2010, Respondent added, without documenting a medical indication, a prescription for Xanax (a benzodiazepine) to the combination of opiates and Vyvanse.

97. During the course of Respondent's treatment, Patient D frequently reported mis-use of opiates. He requested early refills or increased doses. Respondent would grant early refill requests and increase the dosages without documenting medical indications and without any monitoring of the patient. Respondent noted several times in the chart that the patient would come in late and leave early so that he could get to the pharmacy.

98. In or about 2012, Respondent was prescribing on a monthly basis between #300 - #450 Oxycodone IR 30 mg., #60 Xanax, plus Vyvanse to Patient D.

99. During the course of Respondent's treatment, Patient D had increasing medical issues and complications. The patient had a neuro-stimulator placed by the end of 2011. In or about November 2012, the patient reported having suffered a stroke. In December 2012, he was in a car accident.

100. Starting in or about March 2013, Respondent was prescribing monthly to Patient D between #680 to #800 Oxycodone 30 mg.; #90 Xanax; and Vyvanse.

101. In 2014, Respondent noted in the chart that the patient's condition was getting worse. Yet, Respondent continued to issue monthly prescriptions for #800 Oxycodone, #90 Xanax, and Vyvanse.

102. During the course of treatment, Patient D demonstrated multiple behaviors that were indicative of prescription drug misuse. In April 2014, Respondent noted that all the patient cared about were the drugs. Yet, when the patient reported losing his prescription for Oxycodone less than three weeks after a visit, Respondent issued another prescription.

103. On or about May 27, 2014, Respondent issued two prescriptions for #375 Oxycodone IR 30 mg. plus one prescription for #75 Oxycodone IR 30 mg. along with a prescription for #90 Xanax.

104. On or about June 10, 2014, Respondent saw Patient D and noted that the Oxycodone was being discontinued. Respondent wrote a prescription for Suboxone with three refills. The patient was a no-show for his next appointment and he did not return to see Respondent. He did, however, fill the Suboxone prescriptions.

105. Respondent's overall conduct, acts and/or omissions, with regard to Patient D, as set forth in paragraphs 91 through 104 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient D as follows:

a. Without ever performing a complete psychiatric history and assessment of the patient, including a complete medical, substance abuse, and social history, Respondent treated Patient D with controlled substances.

b. Respondent failed to document legitimate medical indications for the prescribing and escalating of doses of multiple controlled substances for long-term use, particularly to an addict such as Patient D.

c. During the course of treatment of Patient D, Respondent failed to maintain clear and complete progress notes, and failed to maintain a clear and updated list of all of the concurrent psychoactive medications and controlled substances that the patient was taking.

d. Respondent did not seek to obtain records from collateral sources regarding the patient's repeated medical hospitalizations and emergency room visits.

e. Respondent failed to document a clear and comprehensive treatment plan and failed to document periodic review of the effectiveness of the treatment.

f. Respondent failed to document that he obtained informed consent from the patient with regard to his treatment of multiple controlled substances, that he discussed the risks, benefits and possible complications of the psychiatric medications, and alternatives to the treatment using

multiple controlled substances, and/or discussed the risk of relapse when prescribing multiple controlled substances to an addict.

g. Respondent failed to order initial and follow-up lab tests and/or failed to document why testing was not needed.

h. Respondent failed to perform routine and/or random urine or blood toxicology screening for this patient who admitted to mis-use of the medications and requested early refills of prescriptions.

i. Respondent prescribed controlled substances to an addict without proper consideration and monitoring.

j. Respondent demonstrated a lack of knowledge and was practicing outside the scope of his practice by prescribing long-term opiates for chronic pain to Patient D.

k. Respondent prescribed multiple controlled substances for long-term use, and at escalating doses, to an addict without documenting a reasonable medical indication.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient E: Gross Negligence and/or Incompetence)

106. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) in that Respondent's overall conduct, acts and/or omissions with regard to Patient E constitutes gross negligence and/or incompetence, as more fully described herein below.

107. On or about January 9, 2015, Patient E, a 36-year old female who was under the temporary conservatorship of Solano County Mental Health, was transferred and admitted to Crestwood Mental Health Rehabilitation Center (Crestwood) in Angwin. Crestwood in Angwin is a 52-bed locked Mental Health Rehabilitation Center. At all times alleged herein, Respondent was the Medical Director of Crestwood in Angwin, a position that he has held since about 1995. Respondent was present at the facility only on Wednesday mornings but was available "on-call" at all times.

108. Patient E had been involuntarily hospitalized at another Crestwood facility in Vallejo from December 23, 2014 until January 9, 2015. Patient E had a history of bipolar disorder and methamphetamine abuse. She had a history of non-compliance, drug use, and homelessness. She

had repeated psychiatric hospitalizations in 2014. The diagnoses at the time of transfer were Bipolar disorder, borderline personality disorder, and methamphetamine abuse. She was admitted on a temporary conservatorship for further stabilization and to find placement.

109. On or about January 14, 2015, Respondent first saw Patient E and noted that she had been diagnosed with schizoaffective disorder and polysubstance use disorder. The current medications were listed as: Lithium 600 mg. bid; Neurontin 300 mg. am and Neurontin 600 mg. at hs; Risperidone 3 mg. bid; Seroquel 50 mg. qis and Seroquel 400 mg. qhs. It was noted that the patient kept stopping her psychiatric medicines. Respondent's impression was schizoaffective disorder bipolar type, and methamphetamine and cannabis use disorder. His plan was to replace the Neurontin with Depakote 750 mg. bid, to change the dosages of Seroquel and of Lithium, to decrease the Risperidone, and to add Clonazepam and Propranolol.

110. On or about January 20, 2015, it was noted by a licensed psychiatric technician that Patient E was over-sedated and was walking around in a stupor and was difficult to understand. Respondent was called and ordered that the Clonazepam be reduced to 1 mg. and that the Seroquel be decreased to 400 mg. qhs.

111. On or about January 21, 2015, the program director at Crestwood Angwin was informed that the patient's writ had been granted by the court and that her conservatorship was terminated. The patient was discharged from the facility and was picked up by her sister later that day.

112. Respondent signed the Physician's Discharge Summary about two weeks after discharge, on or about February 4, 2015. Respondent had not been present at the time of the patient's discharge. The Discharge Summary did not provide a clear and detailed discharge treatment plan with recommendations and instructions, and it did not list the medications provided at discharge. It appears that there were no written follow-up instructions provided to the patient.

113. Respondent's overall conduct, acts and/or omissions, with regard to Patient E, as set forth in paragraphs 106 through 112 herein, constitutes unprofessional conduct through gross negligence and/or incompetence pursuant to Business and Professions Code Sections 2234

subdivisions (b) and/or (d) and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient E as follows:

a. Respondent discharged the patient with prescription medications, including lithium carbonate pills, without providing the patient with a clear and comprehensive discharge medication list that included the medications and dosages, indication, and written follow-up treatment.

b. Respondent signed the discharge summary two weeks after the patient's discharge and the discharge summary was deficient. It did not contain the necessary elements, such as a discharge plan with the pertinent psychiatric part of the treatment course, follow-up treatment recommendations, a list of discharge medications, and written follow-up instructions.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts: Patients A, B, C, D, and/or E)

114. In the alternative, Respondent is subject to disciplinary action for unprofessional conduct under section 2234(c) for repeated negligent acts, jointly and severally, with regard to his acts and/or omissions with regards to Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E, as alleged in paragraphs 33 through 113, which are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Inadequate/Inaccurate Medical Records)

115. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action, jointly and severally, for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to the provision of services to Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E, as alleged in paragraphs 33 through 113, which are incorporated herein by reference as if fully set forth.

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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 G58451, issued to Nathan H. Thuma, M.D.;

2. Revoking, suspending or denying approval of Nathan H. Thuma, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Nathan H. Thuma, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 24, 2017

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

SF2016202369