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

In the Matter of the First Amended Accusation Against:	)	
Robert William Gardner, M.D.	)	**Case No. 800-2015-016263**
Physician's and Surgeon's Certificate No. G 30366	)	
Respondent	)	

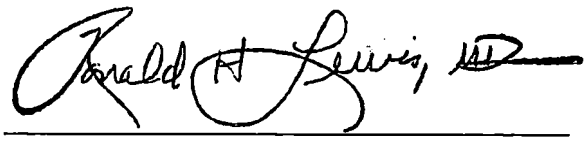
DECISION

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

This Decision shall become effective at 5:00 p.m. on October 11, 2019.

IT IS SO ORDERED: September 12, 2019.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against: **ROBERT WILLIAM GARDNER, M.D.** P.O. Box 1978 Lucerne, CA 95458-1978 Physician's and Surgeon's Certificate No. G 30366 Respondent.	Case No. 800-2015-016263 OAH No. 2019040297 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

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2. Respondent Robert William Gardner, M.D. (Respondent) is represented in this proceeding by attorney Adam G. Slote, whose address is: Slote, Links & Boreman, LLP, One Embarcadero Center, Suite 400, San Francisco, CA 94111-3619.

3. On or about July 25, 1975, the Board issued Physician's and Surgeon's Certificate No. G 30366 to Robert William Gardner, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2015-016263 and will expire on June 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-016263 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 August 9, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. On July 12, 2019, the First Amended Accusation and all other statutorily required documents were properly served on Respondent.

5. A copy of First Amended Accusation No. 800-2015-016263 (the "Accusation") is attached as Exhibit A and 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. 800-2015-016263. 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 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. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-016263, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. 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.

11. 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.

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 Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and 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 30366 issued to Respondent Robert William Gardner, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) 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 Schedule II and Schedule III 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 of the following: 1) the name and address of the 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 Category I certified and shall pertain to prescribing practices and to pain management. 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 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and 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 prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices 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.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and 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. 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 and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, 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 for at least the first year of 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.

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After the first year of probation, Respondent may request that the Board or its designee obtain input from the practice monitor and re-evaluate whether practice monitoring shall be continued or terminated. The determination whether to terminate the practice monitor probation requirement shall be at the discretion of the Board or its designee, and shall not be subject to review or appeal.

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.

6. 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.

7. 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.

8. 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.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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.

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.

10. 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.

11. 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 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. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. 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 the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment 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 for a Respondent residing outside of California 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; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

12. 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.

13. 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.

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14. 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.

15. 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, Adam G. Slote. 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: 8/12/19

Robert William Gardner MD

ROBERT WILLIAM GARDNER, M.D.
Respondent

I have read and fully discussed with Respondent Robert William Gardner, 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: 8/12/2019

ADAM G. SLOTE
SLOTE, LINKS & BOREMAN, LLP
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/12/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Lynne K. Dombrowski

LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2015-016263

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

In the Matter of the First Amended Accusation Against: **Robert William Gardner, M.D.** P.O. Box 1978 Lucerne, CA 95458-1978 Physician's and Surgeon's Certificate No. G 30366, Respondent.	Case No. 800-2015-016263 OAH No. 2019040297 **FIRST AMENDED ACCUSATION**

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation (hereinafter the "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 July 25, 1975, the Medical Board issued Physician's and Surgeon's Certificate Number G 30366 to Robert William Gardner, 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 June 30, 2021, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

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

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

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

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

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

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

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7. Section 2234 of the Code, states in part:

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

"(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. . . ."

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."

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts and/or Incompetence re Patient One)

9. Respondent Robert William Gardner, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 subd. (c) and/or section 2234 subd. (d) in that his care and treatment of Patient One[1] included departures from the standard of care constituting repeated negligent acts and/or incompetence (lack of knowledge). The circumstances are as follows:

10. Patient One was reportedly referred to Respondent's medical clinic by county welfare agencies for treatment of opiate withdrawal. Respondent is certified to administer Suboxone[2] treatment for addiction. According to the certified records produced by Respondent to the Board (hereinafter "certified records"), the first entry in Respondent's medical records for Patient One is dated January 6, 2014. It merely notes an order for a 30-day supply of buprenorphine, for the period January 6 through February 4, 2014. A second chart entry, dated January 15, 2014, prescribes a 30-day supply of Suboxone for the period January 15 through February 13, 2014. This second chart entry provides no explanation for the change in medication prescribed nor what was to transpire with the previously prescribed buprenorphine, of which a quantity for 19 days of the prescribed dose should remain. There was no adequate history and physical examination documented. Respondent is indicated as the provider on both chart entries.

11. Respondent's first documented physical encounter in 2014 with Patient One is dated January 22, 2014. Respondent's notes for this visit state that Patient One "presented with drug abuse." The notes also refer to a positive alcohol test, presumably by one of the county agencies, which Patient One ascribed to cold medication she had taken. Respondent also stated Patient One presented with depression; the only symptom of depression noted is "sleep disturbed." There is no mention of any discussion regarding suicidal ideation or plan. Patient One's vital signs are

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[1] To preserve patient confidentiality, the subject patients are referred to herein by successive numbers. The patients' full names were produced to Respondent in discovery.

[2] Suboxone is a trade name for the compound medication buprenorphine and naloxone. Buprenorphine is an opioid; naloxone (also known as Narcan) is an opioid agonist. Suboxone is employed as a treatment for opioid addiction and is a dangerous drug as defined in section 4022 and a DEA Schedule III controlled substance.

noted, but no physical examination, detailed history, or informed consent for drug treatment/therapy appears in the medical record for this visit.

12. The following week, a second office visit is documented on January 28, 2014. Respondent's notes for this visit identifies Patient One's drug abuse as "opioids...developed plan to titrate off in 2-3 months//CPS wants her off subutex [Suboxone]..."

13. Respondent's notes for the March 18, 2014, visit state that Patient One informed him that she is pleased that she has stopped using marijuana. Marijuana use was not noted previously in Respondent's certified records produced to the Board for 2014. A urinalysis was reportedly done at this office visit, but no reference to the test's results appear in Respondent's certified records for Patient One.

14. According to Respondent's certified records, Respondent saw Patient One with some frequency for the next year, and regularly prescribed Suboxone for her. The next date on which he ordered a urine drug test for Patient One, however, was at the office visit on May 13, 2015, more than a year later.

15. Respondent's chart entries for the office visit dated October 15, 2014, note for the first time that Patient One is taking an antipsychotic medication, which he apparently continues to prescribe for her. There is no indication in Patient One's medical record that Respondent obtained informed consent for the administration of this antipsychotic agent nor that he was managing attendant risks of that therapy, most especially tardive dyskinesia. There is no indication that Respondent performed Abnormal Involuntary Movement Scale testing for Patient One at any point. There is no indication that Patient One was being concurrently seen by a psychiatrist or other provider.

16. Respondent's certified medical records reflect that Respondent did not see Patient One between the May 13, 2015, visit and the visit on November 6, 2015. Respondent continued to regularly prescribe Suboxone to Patient One throughout this period.

17. Respondent continued to prescribe Suboxone for Patient One on a regular basis through mid-2016. According to Respondent's certified records, no documented plan for

treatment or informed consent to treatment with the medications prescribed appears in Respondent's records for Patient One.

18. Respondent's overall conduct, acts and/or omissions with regard to Patient One, as set forth in paragraphs 9 through 17 herein, constitutes unprofessional conduct through repeated negligent acts and/or incompetence pursuant to Business and Professions Code Sections 2234 subdivisions (c) and/or (d) and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient One as follows:

a. Respondent failed to obtain and document effective informed consent for the treatment he afforded Patient One;

b. Respondent did not adequately test and monitor Patient One, who was suffering from what Respondent believed were concurrent substance use disorder, depression, and a thought disorder;

c. Respondent demonstrated a lack of knowledge by failing to consider and manage the risk of tardive dyskinesia in Patient One while she was receiving an antipsychotic medication which brought substantial risk of causing tardive dyskinesia and/or failing to obtain and document informed consent for the prescribing a psychotropic agent;

d. Respondent failed to obtain sufficiently frequent toxicology testing of Patient One while prescribing Suboxone;

e. Respondent failed to document in the patient's chart that he had reviewed the laboratory results and/or copies of the PDMP/CURES patient activity reports and failed to document in the chart a discussion with the patient of abnormal or unexpected results;

f. Respondent's certified records for Patient One were inadequate and lacked specificity with many of the notes being rote and repetitive, not individualized.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate/Accurate Records re Patient One)

19. The allegations of paragraphs 9 through 18 are incorporated by reference as if fully set out herein. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to his care and treatment of Patient One.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts and/or Incompetence re Patient Two)

20. Respondent Robert William Gardner, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 subd. (c) and/or section 2234 subd. (d) in that his care and treatment of Patient Two included departures from the standard of care constituting repeated negligent acts and/or incompetence (lack of knowledge). The circumstances are as follows:

21. Respondent told Board investigators that he has known Patient Two for approximately 30 years. Respondent's certified medical records produced to the Board (hereinafter "certified records") indicate, however, that the first documented treatment that Respondent provided to Patient Two was on July 12, 2013. On that date, Respondent briefly summarized Patient Two's chief complaint and medical history: "back pain hx of gunshot wound//was on methadone clinic//treating self with street oxy and methadone//no needles x 25 years." Patient Two's vital signs were recorded, including a blood pressure reading of 150/113. Respondent listed a diagnosis of sciatica and prescribed methadone.[3] There is no record of an appropriate physical examination, a plan for treatment, or an informed consent in the chart. No treatment plan is included in the chart, nor is an order for laboratory drug screening of Patient Two's blood or urine. Patient Two was instructed to "get records"—presumably from prior providers—and return in one week.

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[3] Methadone hydrochloride is a synthetic narcotic analgesic. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

22. Respondent saw Patient Two the following week on July 19, 2013; he refilled the prescription for methadone and initiated an antihypertensive medication. On July 29, 21013, Patient Two presents to Respondent's office with a complaint of a urinary tract infection for which he was seen in a local emergency department some days prior. Patient Two was seen by Respondent's family nurse practitioner, who documented a superficial physical examination that suggests Patient Two is "in distress secondary to pain." Under the chart entries labeled "Psychiatric" the nurse practitioner notes "eye contact: yes patient swears he does not wish to abuse drugs DOJ report [CURES?] indicates otherwise..." No plan for treatment is noted; in a formulaic paragraph the nurse practitioner documents counseling Patient Two as to the benefits and risks of "the medication" and states that Patient Two was aware of the effects of alcohol in combination with "this medication." Respondent's nurse practitioner prescribed an oral antibiotic, continued the blood pressure medication, and increased Patient Two's daily dose of methadone by 50%.

23. On October 2, 2013, Respondent's certified records indicate that his nurse practitioner saw Patient Two, noting that Patient Two had undergone a laminectomy on August 28, 2013, during which time "he did not have Adderall[4]..." evidently taken for what Patient Two described as compulsion ADD. There is no prior mention in Respondent's records for Patient Two receiving Adderall or having ADD. In the notes for this visit, Attention Deficit Disorder with Hyperactivity is added to Sciatica as the listed diagnoses. Under the chart section labeled "Psychiatric," Respondent's nurse practitioner noted only that Patient Two's affect and mood

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[4] Adderall, a trade name for mixed salts of a single-entity amphetamine, is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Adderall is indicated for Attention Deficit Disorder with Hyperactivity and for Narcolepsy. It is contraindicated for patients with advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, agitated states, or a history of drug abuse,

(continued...)

were "pleasant." The nurse practitioner added alprazolam[5] and carisoprodol[6] to Patient Two's prescribed medications on this visit and increased the amount of methadone prescribed from 60 to 80 milligrams per day; no treatment plan is present and the "informed consent" is a rote repetition of the formulaic entry first entered on the July 29, 2013 visit.

24. On October 25, 2013, Respondent's nurse practitioner saw Patient Two, noting the patient complained of "disturbances of thinking. It is described as stable doing well with decrease of Adderall." There are no other clinical descriptions or findings entered in the chart for this visit; no plan of treatment or objectives for the drug regimen prescribed are included in the patient's chart. Chart notes on this visit indicate that Adderall is "deleted" from the list of medications Patient Two is receiving. Respondent's nurse practitioner added Fiorinal[7] and Klonopin[8] on this visit to the list of medications given to Patient Two.

25. Respondent saw Patient Two again on November 8, 2013, noting that the patient had "relapsed on opiates...been on suboxone before...old heroin user..." Respondent discontinued the methadone and began prescribing Suboxone to Patient Two.

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[5] Alprazolam (trade name Xanax)is a psychotropic medication of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam.

[6] Carisoprodol is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

[7] Fiorinal is a trade name for an analgesic containing 50 mg. of butalbital, a barbiturate, caffeine, and aspirin. It is a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined by section 11056 of the Health and Safety Code. Butalbital, acetaminophen, and caffeine may enhance the effects of other narcotic analgesics, alcohol, general anesthetics, tranquilizers, sedative-hypnotics, or other CNS depressants.

[8] Klonopin is a trade name for clonazepam, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, Klonopin can produce psychological and physical dependence.

26. The first drug screen Respondent ordered for Patient Two appears to have been performed on December 6, 2013. The results are positive for amphetamine, barbiturate, benzodiazepines, and THC/marijuana.

27. In the chart notes for a visit on February 5, 2014, Respondent's nurse practitioner states that "pt appears to be loaded at this time...I don't see pt often enough to get a good read on him but my 'BS meter' is going off..."

28. At an office visit on March 19, 2014, Respondent stated that Patient Two again presented with "disturbances of thinking "--noting that Patient Two reported "hearing voices-accusatory//mental illness runs in family." Respondent refilled Patient Two's prescription medications in multiple occasions over the next two weeks and saw Patient Two again on April 2, 2014. At this visit Respondent began prescribing an antipsychotic medication for Patient Two. There is no psychiatric evaluation or referral noted in the chart, nor is there informed consent or a plan of treatment documented in connection with this new prescription. At this point Respondent's medical record for Patient Two indicates that the current medications then being prescribed to the patient includes a dozen medications, including Suboxone, Adderall, and Valium,[9] to which Respondent added antipsychotic medication.

29. At an office visit on October 15, 2014, Respondent notes that Patient Two's neck and back pain are "too severe for suboxone..." Respondent resumes prescribing methadone to Patient Two on this visit. On October 22, 2014, Patient Two's current medication list is expanded to include approximately 16 prescription medications.

30. On or about December 4, 2014, a urine toxicology screen report reflected positive results for THC, amphetamines, barbiturates, and benzodiazepine but there is no subsequent documentation of a discussion with the patient about these results and a rationale for the medications prescribed.

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[9] Valium is a trade name for diazepam, a psychotropic drug for the management of anxiety disorders. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Diazepam can produce psychological and physical dependence.

31. Respondent's overall conduct, acts and/or omissions with regard to Patient Two, as set forth in paragraphs 20 through 30 herein, constitutes unprofessional conduct through repeated negligent acts and/or incompetence pursuant to Business and Professions Code Sections 2234 subdivisions (c) and/or (d) and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient Two as follows:

a. Respondent failed to obtain and document effective informed consent for the treatment he afforded Patient Two;

b. Respondent failed to obtain a psychiatric evaluation for Patient Two while he was prescribing an antipsychotic medication to this patient;

c. Respondent continued to prescribe a varying regimen of drugs to Patient Two without adequate periodic review, without a defined treatment plan, and without clinical justification for initiating, continuing, or changing the medications prescribed;

d. Respondent failed to adequately document and address that Patient Two was actively using illicit substances in a pattern that meets criteria for a number of substance use disorders.

e. Respondent demonstrated a lack of knowledge in prescribing carisoprodol, butalbital and zaleplon to Patient Two who admitted to consuming alcohol;

f. Respondent demonstrated a lack of knowledge in not performing an AIMS during treatment and in providing thiothixene with persisting symptoms of psychosis being reported, without a referral to a psychiatrist.

g. Respondent failed to perform and document an adequate initial history and physical examination of Patient Two and failed to document findings to support the diagnosis of sciatica;

h. Respondent noted elevated blood pressures for Patient Two without documenting a plan or intervention;

i. Respondent failed to document and address positive and/or unexpected results of a urine toxicology screen.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate/Accurate Records re Patient Two)

32. The allegations of paragraphs 20 through 31 are incorporated by reference as if fully set out herein. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to his care and treatment of Patient Two.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts and/or Incompetence re Patient Three)

33. Respondent Robert William Gardner, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 subd. (c) and/or section 2234 subd. (d) in that his care and treatment of Patient Three included departures from the standard of care constituting repeated negligent acts and/or incompetence (lack of knowledge). The circumstances are as follows:

34. According to Respondent's certified records, Patient Three was apparently referred to Respondent for treatment by a county agency; she first saw Respondent on February 21, 2014. Respondent's chart notes for this visit state that Patient Three has "opiate problems...iv heroin...." Respondent's only notes reflecting a physical examination state that Patient Three's pupils were dilated and her skin clammy. Respondent charts a diagnosis of "Anxiety State." In an interview with Board investigators, Respondent acknowledged that Patient Three's clinical symptoms on February 21, 2014 were indicative of active opiate withdrawal, but that he recorded anxiety as the presenting problem "because it's more an insurance and sign of the times issue." Respondent prescribed Suboxone to Patient Three on this initial visit. There is no indication in the medical record that Respondent performed an appropriate physical examination, formulated a treatment plan for Patient Three, that he obtained informed consent for treatment with Suboxone, or that Respondent obtained a toxicology screen of Patient Three's urine or blood. There is no reference of an induction performed upon prescribing of Suboxone, nor of assessment of Patient Three on the Clinical Opiate Withdrawal Scale (COWS).

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35. Respondent refilled the prescription for Patient Three's Suboxone on March 10, 2014, and saw Patient Three again in his clinic on March 14, 2014. On March 14 and again on the April 8, 2014, office visit, Respondent refilled Patient Three's Suboxone prescription and apparently accepted the patient's assertion that she had not been abusing opiates. In the record of the April 18, 2014, office visit, Respondent noted that Patient Three had "relapsed with opiates." No other information reflecting Respondent's awareness of the patient's relapse, or any clinical response to that new information, appears in the medical record.

36. By June 6, 2014, Respondent noted that in his care Patient Three had "tapered off with suboxone//no urges." The next contact with Patient Three noted in Respondent's medical records was on December 3, 2014; the chart notes merely indicate a re-fill of Patient Three's Suboxone prescription.

37. Patient Three's next documented visit occurred on October 15, 2015. Respondent's physician assistant saw Patient Three for complaint of lower limb edema and pain and inguinal hernia. Patient Three was seen intermittently thereafter by Respondent's physician assistant for a variety of complaints. On February 2, 2016, the physician assistant apparently prescribed Ativan[10] for anxiety. There is no documentation in the medical record of any focused history pertaining to the anxiety for which this medication was prescribed, nor is there any indication that Patient Three was referred for a psychiatric evaluation for anxiety.

38. Respondent's physician assistant continued to prescribe Ativan and medications for various physical maladies to Patient Three over the next eight months. The notes for an office visit on October 4, 2016, indicate the physician assistant ordered a urine toxicology screen; a sample was obtained from Patient Three that day and the results—positive readings for alcohol metabolites, opiates, and amphetamines—were reported to Respondent's clinic on October 13,

[10] Ativan is a trade name for lorazepam, a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057, subdivision (d) of the Health and Safety Code. It has a central nervous system depressant effect. Lorazepam can produce psychological and physical dependence and it should be prescribed with caution to individuals with an history of substance dependence/abuse.

2016. Although Patient Three was still being prescribed a benzodiazepine, no benzodiazepine was present in the sample collected on October 4, 2016.

39. Patient Three was next seen in Respondent's offices on July 31, 2017. Nothing in Respondent's medical record reflects in discussion with Patient Three about the results of her lab tests or a treatment plan to address the findings of the toxicology screen. During that visit, the focus of treatment is "unspecified abdominal pain" but there is no documentation that a physical examination of the abdomen was performed. The patient was apparently referred for an ultrasound of the gall bladder but there are no lab results or documentation of follow-up in Respondent's certified records.

40. Respondent's overall conduct, acts and/or omissions with regard to Patient Three, as set forth in paragraphs 33 through 39 herein, constitutes unprofessional conduct through repeated negligent acts and/or incompetence pursuant to Business and Professions Code Sections 2234 subdivisions (c) and/or (d) and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient Three as follows:

a. Respondent's documentation of a diagnosis unsupported by objective clinical data for purposes of meeting standards for compensation by insurers was a departure from the standard of care;

b. Respondent failed to obtain regular and timely toxicology screens on a patient with an identified substance abuse history to whom Respondent was prescribing controlled substances;

c. Respondent filled prescriptions for five months without a documented visit with Patient Three;

d. Respondent performed only one toxicology screen on Patient Three for the treatment period of February 2014 to November 2017;

e. Respondent demonstrated a lack of knowledge by providing both a benzodiazepine and an opiate to Patient Three, a person with an established opiate addiction;

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f. Throughout his treatment of Patient Three, Respondent failed to clearly and concisely document the rationale and the progress of treatment.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate/Accurate Records re Patient Three)

41. The allegations of paragraphs 33 through 40 are incorporated by reference as if fully set out herein. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to his care and treatment of Patient Three.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re Patients A and/or B and/or C)

42. In the alternative, Respondent Robert William Gardner, M.D. is subject to disciplinary action for unprofessional conduct under section 2234, subd. (c) in that his care and treatment of Patient One and/or Patient Two and/or Patient Three included departures from the standard of care constituting repeated negligent acts. The allegations of paragraphs 9 through 41 above are incorporated by reference as if fully set out herein.

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 G 30366, issued to Robert William Gardner, M.D.;

2. Revoking, suspending or denying approval of Robert William Gardner, M.D. 's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert William Gardner, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: July 12, 2019

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

SF2018200965