XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
CHRISTINA SEIN GOOT
Deputy Attorney General
State Bar No. 229094
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6481
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: WARDEN HAMLIN EMORY, M.D. 2080 Century Park East, Suite 1409 Los Angeles, CA 90067 Physician's and Surgeon's Certificate No. C 31807, Respondent.	Case No. 800-2017-039397 **ACCUSATION**

PARTIES

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

2. On November 5, 1969, the Board issued Physician's and Surgeon's Certificate Number C 31807 to Warden Hamlin Emory, M.D. (Respondent). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2023, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. 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.

5. 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The 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.

6. 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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FACTUAL ALLEGATIONS

7. At all times relevant to the allegations herein, Respondent practiced psychiatry in Los Angeles, California. Respondent also provided treatment for physical and chronic pain.

Patient 1

8. Respondent treated Patient 1, a male in his 40's, from approximately 2003 until 2008. Thereafter, Patient 1 treated with another physician. Patient 1 then returned to Respondent and treated with him from 2012 until 2018. Respondent diagnosed Patient 1 with anxiety, depression, and attention deficit hyperactivity disorder (ADHD). Respondent also treated Patient 1 for chronic pain.

9. Respondent regularly prescribed Patient 1 high doses of opioids and benzodiazepines; however, there was no discussion of an opioid agreement or the potential risks of combining opioids and benzodiazepines documented in the medical record. In addition, there was no risk stratification, urine testing, or regular review of the Controlled Substance Utilization, Review and Evaluation System (CURES). Respondent's evaluation of respiratory depression risk related to the combination of an opioid and benzodiazepine by solely evaluating electroencephalogram (EEG) data is not consistent with the standard of care. On several occasions, Patient 1 was seen many days after he had run out of his medication early. Respondent failed to explore in-depth the reasons why this occurred. In addition, Patient 1 was an out-of-state patient paying Respondent by cash. This presented potential concerns that he could obtain controlled substances from out-of-state physicians that would not show up on CURES, even if Respondent had regularly reviewed CURES reports (which he did not). This was an extreme departure from the standard of care.

10. When Patient 1 first returned to Respondent's care, Respondent failed to document any attempts to obtain records from Patient 1's prior treating physician. This was a simple departure from the standard of care.

11. Throughout his treatment of Patient 1, Respondent regularly prescribed controlled substances for pain. Discussions of the risks and benefits of these controlled substances were poorly documented (or not documented at all), and there was no opioid agreement with the

patient. This was a simple departure from the standard of care.

12. Respondent did not make any significant effort to assure that the controlled substances he prescribed were not being diverted by the patient. There was no discussion with the patient of the issue of potential diversion and no periodic urine toxicology screening (not only to look for illicit or unprescribed substances, but also to make sure the prescribed medications were actually being taken). This was a simple departure from the standard of care.

13. Respondent terminated the physician-patient relationship with Patient 1; however, his letter terminating the relationship did not (a) contain any reference to providing at least 15 days of emergency treatment and prescriptions before discontinuing Respondent's availability; (b) include alternative sources of medical care, or (c) contain the information necessary for Patient 1 to obtain his medical records, as is required by the standard of care. This was a simple departure from the standard of care.

Patient 2

14. Respondent treated Patient 2, at the time a 35-year-old male, from approximately January 2015 through October 2018. Respondent diagnosed Patient 2 with anxiety, depression, avoidant traits, hypothyroidism, hypotestosteronemia[1], and cryptogenic insomnia, that is, insomnia of an unknown cause. Respondent also treated Patient 2 for chronic pain.

15. Respondent regularly prescribed Patient 2 opioids, benzodiazepines, and muscle relaxants. There was no discussion with this patient of an opioid agreement or the risks of combining opioids, benzodiazepines, and ketamine. In addition, there was no risk stratification, urine testing, or regular review of CURES. Patient 2 also reported that he would have likely committed suicide without Respondent's help; however, there was no further documentation about a discussion of suicidality with this patient nor was there any discussion of how the patient should dispose of the ketamine he was no longer using. This was an extreme departure from the standard of care.

16. At the January 8, 2015 visit, Respondent noted that Patient 2 had been acquiring

[1] This terms refers to abnormally low testosterone production; possibly due to testicular dysfunction (primary hypogonadism) or hypothalamic-pituitary dysfunction (secondary hypogonadism). It may be congenital or acquired.

Norco 7.5/325 from a local physician but that he had to wait in her office waiting room monthly for the refill. Respondent then prescribed Patient 2 a 6-month supply of Norco. Respondent's records do not indicate that he contacted the patient's other physician to advise that he would be taking over management of the opioids or to inquire if there were specific concerns/reasons to require monthly visits from Patient 2. This was a simple departure from the standard of care.

17. Throughout his treatment of Patient 2, Respondent regularly prescribed controlled substances for pain. Discussions of the risks and benefits of these controlled substances were poorly documented (or not at all), and there was no opioid agreement with the patient. This was a simple departure from the standard of care.

18. Respondent did not make any significant effort to assure that the controlled substances prescribed were not being diverted by the patient. There was no discussion with the patient of the issue of potential diversion and no periodic urine toxicology screening (not only to look for illicit or unprescribed substances, but also to make sure the prescribed medications were actually being taken). This was a simple departure from the standard of care.

Patient 3

19. Respondent treated Patient 3, a 68-year-old female at the time, from May 2015 until August 2018. Respondent diagnosed Patient 3 with unspecified anxiety, unspecified depression, and unspecified sleep stage disorder. Respondent also treated Patient 3 for chronic pain.

20. Patient 3 owned a jet and would travel back and forth between Arizona, Michigan, and Los Angeles. Her living arrangements posed a potential risk of medication misuse or diversion. She had both the financial and physical means to readily and regularly travel out of state and pay cash (which was how she paid Respondent) for essentially untraceable visits with physicians whose out-of-state prescriptions would not show up on a CURES report, even if Respondent had checked them regularly (which he did not). In such a patient, drug toxicology screening and a clear medication contract/agreement would be a cornerstone of responsible management if that management involved the prescription of controlled substances. Respondent prescribed Patient 3 opioids and benzodiazepines, among other medications. In addition to a lack

of toxicology screening, regular review of CURES reports,[2] and an opioid agreement, there was no clear assessment of the risk of substance abuse, misuse, or addiction. This was an extreme departure from the standard of care.

21. Patient 3 had knee surgery during the time she treated with Respondent. Ten weeks post-surgery, Patient 3 reported feeling worse after her dose of Vicodin had been decreased. Respondent increased Patient 3's dose of Vicodin without consulting with the patient's knee surgeon. Respondent acknowledged that it would have been prudent to have Patient 3 return to see her surgeon. This was a simple departure from the standard of care.

22. Throughout his treatment of Patient 3, Respondent regularly prescribed controlled substances for pain. Discussions of the risks and benefits of these controlled substances were poorly documented (or not at all), and there was no opioid agreement with the patient. This was a simple departure from the standard of care.

23. Respondent did not make any significant effort to assure that the patient was not diverting the controlled substances prescribed. There was no discussion with the patient of the issue of potential diversion and no periodic urine toxicology screening (not only to look for illicit or unprescribed substances but also to make sure the prescribed medications were actually being taken). This was a simple departure from the standard of care.

Patient 4

24. Respondent treated Patient 4, a 23-year-old male at the time, from May 2015 through October 2018. Respondent diagnosed him with anxiety, depressed mood, attention deficit "secondary to NP variance," thyroiditis, chronic pain, "[n]eurodevelopmental tachycardia," and insomnia.

25. During his course of treatment, Respondent regularly prescribed Patient 4 amphetamines and opioids. There was no discussion with the patient of an opioid agreement or the risks of combining opioids and ketamine. In addition, there was no risk stratification, urine testing, or regular review of CURES. This was an extreme departure from the standard of care.

[2] As mentioned previously, in the case of Patient 3, CURES alone would be insufficient to track the patient's prescription refills that occurred out of state.

26. Throughout his treatment of Patient 4, Respondent failed to consult with a cardiologist or any other physician regarding the patient's tachycardia. Respondent performed an EEG that included a single channel of electrocardiogram (EKG); however, its diagnostic utility is limited and is not intended as a replacement for a 12-lead EKG. Respondent's failure to consult with a cardiologist or other specialist was a simple departure from the standard of care.

27. Throughout his treatment of Patient 4, Respondent regularly prescribed controlled substances for pain. Discussions of the risks and benefits of these controlled substances were poorly documented (or not at all), and there was no opioid agreement with the patient. This was a simple departure from the standard of care.

28. Respondent did not make any significant effort to assure that the patient was not diverting the controlled substances prescribed. There was no discussion with the patient of the issue of potential diversion and no periodic urine toxicology screening (not only to look for illicit or unprescribed substances but also to make sure the prescribed medications were actually being taken). This was a simple departure from the standard of care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patients 1, 2, 3, and 4)

29. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence in his care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

30. Complainant refers to and, by this reference, incorporates paragraphs 7 through 28, above, as though set forth fully herein.

31. Respondent failed to adequately perform risk stratification during his course of treatment of Patients 1, 2, 3, and 4, which constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patients 1, 2, 3, and 4)

32. Respondent is further subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

33. Complainant refers to and, by this reference, incorporates paragraphs 7 through 28, above, as though set forth fully herein.

34. Respondent's treatment of Patients 1, 2, 3, and 4 include the following acts and/or omissions which constitute repeated negligent acts:

a. The allegations of the First Cause for Discipline are incorporated by reference as if fully set forth herein.

b. Respondent failed to document any attempts to obtain appropriate documentation from other health care providers of Patients 1, 2, and 4;

c. Respondent inadequately documented (or did not document at all) discussions of the risks and benefits of controlled substances and/or did not obtain opioid agreements with Patients 1, 2, 3, and 4;

d. Respondent failed to document any attempts to refer Patients 2, 3, and 4 to relevant specialists and/or a pain management specialist;

e. Respondent failed to make any significant effort to assure that the controlled substances prescribed were not being diverted by Patients 1, 2, 3, and 4; and

f. Respondent's letter terminating the physician-patient relationship with Patient 1 did not (1) contain any reference to providing at least 15 days of emergency treatment and prescriptions before discontinuing Respondent's availability; (2) include alternative sources of medical care; or (3) contain the information necessary for Patient 1 to obtain his medical records.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record-Keeping – Patients 1, 2, 3, and 4)

35. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate records concerning the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

36. Complainant refers to and, by this reference, incorporates paragraphs 7 through 28, above, as though set forth fully herein.

37. The allegations of the Second Cause for Discipline are incorporated by reference as if fully set forth 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 C 31807, issued to Warden Hamlin Emory, M.D.;

2. Revoking, suspending or denying approval of Warden Hamlin Emory, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering Warden Hamlin Emory, M.D. to pay the Board the costs of probation monitoring; and

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

DATED: 12/11/2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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