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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: **RONALD PAUL RISLEY, M.D.** **701 Howe Ave., Ste. H50** **Sacramento, CA 95825-4604** **Physician's and Surgeon's Certificate No. A 63721,** Respondent.	Case No. 800-2018-048920 OAH No. 2022010669 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about October 17, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63721 to Ronald Paul Risley, 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 January 31, 2023, unless renewed.

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 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.

STATUTORY PROVISIONS

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

> The board shall take action against any licensee who is charged with unprofessional conduct.[1] 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.
>
> ...

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[1] Unprofessional conduct under California and Business Code section 2234 is conduct which breaches the rules of the ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

6. Section 2228.1 of the Code states, in pertinent part:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

...

7. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

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

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

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

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

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

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

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

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 4021 of the Code states: 'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

10. Section 4022 of the Code states: 'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"...

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and

enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

PERTINENT DRUG INFORMATION

12. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is a short-acting medication commonly used for the short-term management of anxiety disorders, specifically panic disorder or generalized anxiety disorder. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Aripiprazole – Generic name for the drug Abilify, among others. Aripiprazole is an atypical antipsychotic, primarily used in the treatment of schizophrenia and bipolar disorder. Other uses include as an add-on treatment in major depressive disorder, tic disorders, and irritability associated with autism. It is taken by mouth or injection into a muscle. Aripiprazole is a dangerous drug pursuant to California Business and Professions Code section 4022.

14. Buprenorphine– Generic name for Butrans, which is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 §1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code §4022.

15. Clonazepam – Generic name for the drug Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder, and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is also a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Duloxetine – Generic name for Cymbalta. Duloxetine is a selective serotonin and norepinephrine reuptake inhibitor antidepressant (SSNRI) medication used to treat depression and

anxiety in addition to help relieve nerve pain (peripheral neuropathy) in people with fibromyalgia. It is a dangerous drug pursuant to Business and Professions Code section 4022.

17. Gabapentin – Generic name for Neurontin. Gabapentin is a medication used as an anticonvulsant and analgesic used to treat epilepsy. It is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

19. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast-acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Methadone hydrochloride – Generic name for the drugs Adanon, Althose, Dolophine, and Methadose. Methadone hydrochloride is a synthetic opioid with analgesic activity similar to

[2] Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

morphine and other morphine-like agents. Methadone mimics the actions of endogenous peptides at central nervous system (CNS) opioid receptors, primarily the mu receptor. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Methylphenidate – Generic name for the drug Ritalin. Methylphenidate is a stimulant drug used to treat Attention deficit hyperactivity disorder (ADHD) and narcolepsy. Methylphenidate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308. 12. Methylphenidate is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

23. Morphine sulfate – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Oxycodone – Generic name for the drugs Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependency. It can cause respiratory distress and even death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

25. Oxycodone with acetaminophen– Generic name for the drugs Endocet and Percocet. It is an opioid analgesic combination product used to treat moderate to severe pain. Oxycodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

26. Oxymorphone – Generic name for the drug Opana. Oxymorphone is a potent opioid analgesic drug with an abuse liability similar to morphine and other Schedule II opioids. Oxymorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. Sertraline – Generic name for the drug Zoloft. Sertraline is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. It is used to treat major depressive disorder, obsessive– compulsive disorder, panic disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, and social anxiety disorder. Sertaline is a dangerous drug, pursuant to Business and Professions Code, section 4022.

28. Tramadol – Generic name for name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section l 308. l4(b). It is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c).

29. Trazodone – Trazodone was an antidepressant medication used to treat major depressive disorder and anxiety disorder and is also used treat insomnia. Trazodone is a dangerous drug pursuant to Business and Professions Code section 4022.

30. Zolpidem tartrate – Generic name for the drug Ambien. Zolpidem tartrate is a sedative and hypnotic used for short-term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is

a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

31. Respondent is a physician and surgeon, board certified in family medicine, who at all times relevant to the allegations brought herein worked within Sacramento County, California at Sacramento Medical Oasis, Inc.

Patient 1[3]

32. Patient 1, a 57-year-old female patient, had a prior documented history of a Schatzki's ring (scar tissue in the esophagus), heartburn, allergies, high cholesterol, menopause, fatty liver, chronic sinus issues, mitral regurgitation (an abnormal heart valve), pre-diabetes, chronic pain, insomnia, hypothyroidism, fibromyalgia, depression, Post-traumatic stress disorder (PTSD), herpes, and high blood pressure prior to becoming Respondent's patient on or about March 4, 2016. Patient 1 had also previously undergone surgeries that included right hip acetabuloplasty (arthroscopic surgery shaving away abnormal bone), hysterectomy, breast implants, left ovary removal, and leg surgery. Respondent treated Patient 1 at his private medical practice from approximately March 2016 until her death in November 2018. Between March 2016 and her death in November 2018, Patient 1 continued to receive controlled substances as a result of Respondent's prescriptions following her last visit in September 2018.

33. On or about March 3, 2016, Respondent printed a CURES[4] report for Patient 1 which demonstrated Patient 1 received 30 Ambien CR at 12.5 mg per month from one physician. Another physician prescribed Xanax ER at 2 mg one a day, Xanax IR 1 mg at one a day, Norco 10/325 at one to two per day, and methadone at 30 mg per day monthly from September 2015 through December 2015, then 10 mg to 15 mg per day in January and February of 2016. This

[3] To protect the privacy of the patients and witnesses involved, the patients and witnesses names were not included in this pleading. Respondent is aware of the identity of each patient and witness. All patients and witnesses will be fully identified in discovery.

[4] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

equates to approximately 260 morphine milligram equivalents (MME)[5] per day while on the higher dose methadone and 280 MME while on the 15 mg per day dose. The CURES report also demonstrated Patient 1 had received one prescription for 90 tablets of tramadol from a physician on December 16, 2015.

34. During a July 8, 2021 interview with a Department of Consumer Affairs Health Quality Investigation Unit (HQIU) Investigator, Respondent was asked about calculating MME and written pain contracts with patients in his practice. Respondent stated he "generally does not" calculate MME and does not "do contracts with patients." Respondent also claimed that he did not have Patient 1's prior medical records available when he first began treating her in 2016.

35. On or about March 4, 2016, Patient 1 first saw Respondent to establish care and obtain prescription medication refills. Patient 1 had missed two previous appointments prior to this date and arrived late on March 4, 2016. Patient 1 reported taking levothyroxine (thyroid medication); atenolol-HCTZ for high blood pressure; trazodone at 50 mg three tablets in the evenings; methadone at 30 mg per day; Norco twice a day for anticipated hip and knee surgery; tramadol three times per day; Xanax at 1 mg and Xanax Extended Release at 2 mg; Valtrex (valacyclovir for viral infections such as herpes); Zoloft; and hormone patches. Patient 1 reported previously being on Abilify but discontinued use due to the side effects. Patient 1 also reported to Respondent that she had a history of depression, fibromyalgia, chronic insomnia, with an enlarged heart, and that she suffered from hip pain and was seeing an orthopedic surgeon for arthritis while seeing a psychiatrist and being prescribed sleep medications and tramadol. Patient 1 disclosed smoking almost a pack of cigarettes per day while consuming a couple of alcoholic drinks throughout the week. Respondent conducted an examination of Patient 1 at this visit which was significant for normal vital signs and normal mental status exam; however, no examination was conducted as to Patient 1's thyroid, heart, lungs, hips, back, or knees. Respondent diagnosed

[5] Morphine Milligram Equivalents ("MME") and Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf at page 17.

Patient 1 as having a "difficult childhood, multiple medication sensitivities, fibromyalgia, major depressive disorder, PTSD, bilateral hip osteoarthritis with marked chronic pain, moderate to severe insomnia" and ordered laboratory studies. Respondent renewed Patient 1's prescriptions for levothyroxine; atenolol/chlorthalidone; estradiol patch; 90 methadone at 10 mg; Valtrex; 60 Norco at 10/325 mg; 30 Ambien at 12.5 mg; and he increased her trazodone from 150 mg to 200 mg per night. Respondent documented in Patient 1's medical records discussing the risks of combining methadone with benzodiazepines, wherein Patient 1 chose to stop the Xanax and Respondent warned her about withdrawal symptoms. There is no indication in Patient 1's medical records of Respondent discussing or reviewing Patient 1's prior medical records or X-rays on this date.

36. On or about April 1, 2016, Patient 1 was seen by Respondent and she reported that her pain was "status quo, increasing...," that she had some panic attacks when she stopped taking Xanax, and was now smoking a pack of cigarettes per day. She told Respondent that she had tried nonsteroidal anti-inflammatory drugs (NSAIDs) in the past but they did not control her pain, so she was started on opioids. Patient 1 also reported taking Advil up to 800 mg per day and not having a bone density test or mammogram "in a while." She informed Respondent that the pharmacy "accidentally" filled a prior prescription for her Ambien from a different physician. Patient 1 requested referrals to a dermatologist and an OB/GYN from Respondent and wanted to "try Wellbutrin." Respondent performed a mental status evaluation with an assessment identical to the March 4, 2016 visit, but no other physical examination. There is no indication in Patient 1's medical records for this date of the previously ordered labs from March 4, 2016. Respondent refilled Patient 1's prescriptions for levothyroxine; atenolol/chlorthalidone; trazodone; estradiol patch; Valtrex; and zolpidem ER at the same doses for one month with a refill. Respondent increased Patient 1's prescription for methadone from 90 per month to 120 per month (40 mg per day) to be filled that date; continued Norco 10/325 at 60 per month; and added omeprazole (proton-pump inhibitor used to treat heartburn, a damaged esophagus, stomach ulcers, and gastroesophageal reflux disease) at 40 mg; and Wellbutrin SR 150 mg one every morning for

smoking cessation.[6] On this same day, Respondent printed Patient 1's CURES report. Approximately one week after this visit, Respondent refilled Patient 1's Zoloft prescription via the telephone.

37. On or about April 29, 2016, Patient 1 was seen by Respondent and reported that her pain was better, that the Wellbutrin was helping, but that she had not cut down on her smoking. Patient 1 did not complete the previously ordered laboratory studies. Respondent performed an examination and assessment similar to the previous visits and refilled Patient 1's medications, while adding an extra tablet of Wellbutrin XL 300 mg to the SR 150 mg.

38. On or about June 2, 2016, Patient 1 was seen by Respondent and she reported that her pain was a "little worse" and that she decreased her cigarette intake from 20 to 5 cigarettes per day. Patient 1 did not complete the previously ordered laboratory studies. Respondent performed an examination and assessment similar to the previous visits, reordered labs, and refilled her medications similar to her previous visit on April 29, 2016, while increasing her methadone prescription from 120 to 135 pills per month.[7] On this same day, Respondent printed Patient 1's CURES report. Respondent also referred Patient 1 to an orthopedic surgeon.

39. On or about June 28, 2016, Respondent's Physician Assistant refilled Patient 1's methadone and Norco by telephone, which were also refilled by Respondent by telephone on or about August 3, 2016. On or about August 3, 2016 and September 1, 2016, Respondent printed Patient 1's CURES reports.

40. On or about September 1, 2016, Patient 1 was seen by Respondent and she reported feeling better with some anxiety, but was still smoking 2-3 cigarettes per day and still had not completed the previously ordered laboratory studies. Patient 1 also told Respondent that she "tried taking extra methadone that was left over from her mother and found that she did well at 30, 30, and 20 mg. Has been on that dose for 10 days without sedation." Respondent performed an examination and assessment similar to the previous visits without musculoskeletal or cardiovascular examinations, reordered labs again with an added urine toxicology, and refilled

[6] This equates to an MME of 340 mg per day.
[7] This equates to an increase of Patient 1's MME to approximately 450 mg per day.

her medications while increasing Patient 1's methadone prescription from 135 to 240 pills per month.[8] Patient 1's urine toxicology study did not include testing for illicit substances, but did detect the presence of methadone and was negative for benzodiazepines.

41. During the July 8, 2021 interview, Respondent was asked why he increased Patient 1's methadone from approximately 240 MME per day to approximately 1,000 MME per day in a 6 month period, to which Respondent stated that he believed Patient 1's pain was not adequately controlled and that she had a progressive condition, specifically osteoarthritis of the hip.

42. On or about September 30, 2016, Patient 1 was seen by Respondent and she reported "feeling about the same...or better," but still had not completed the previously ordered blood work laboratory studies. Respondent performed an examination and assessment similar to the previous visits, except Respondent recorded no blood pressure in Patient 1's record. Respondent reordered labs again, refilled Patient 1's medications similar to her previous visit at the same dosages, and printed Patient 1's CURES report.

43. On or about November 3, 2016, Patient 1 arrived late to her appointment and was seen limping by Respondent, and reported her pain as an "8-9." Patient 1 had not completed the previously ordered laboratory studies, and there is no indication in Patient 1's medical records of the prior bone densitometry X-ray, mammogram, orthopedic surgery, OB/GYN, or dermatology referrals from April 1, 2016. Respondent performed an examination and assessment similar to the previous visits, reordered labs again, refilled her medications similar to her previous visit at the same dosages, and printed Patient 1's CURES report.

44. On or about December 1, 2016, Patient 1 was seen by Respondent and she reported feeling constantly depressed. Regarding her pain, Patient 1 told Respondent she did not feel good but did not want to increase her pain medications. Patient 1 also reported taking two hydrocodone at lunchtime and none at night, which she believed was helpful for her pain during the day. Patient 1 still had not completed the previously ordered blood work laboratory studies. Respondent performed an examination and assessment similar to the previous visits, reordered labs again, refilled her medications similar to her previous visit at the same dosages while

[8] This equates to an increase of Patient 1's MME to approximately 980 mg per day.

increasing her prescription for Norco from 60 to 90 per month, and advised her to stop taking the Valtrex.[9]

45. During the July 8, 2021 interview, Respondent was asked why Patient 1 increased her use of hydrocodone in December of 2016, to which Respondent stated that he believed Patient 1 "was having more breakthrough pain due to progression of her disease."

46. On or about January 6, 2017, Patient 1 was seen by Respondent and she reported being in constant pain and in fear of addiction. She also reported taking some old oxycodone with methadone and stated that "I'm at the point where I have to think twice about getting up." Patient 1 still had not completed the previously ordered blood work laboratory studies. Respondent performed an examination and assessment similar to the previous visits, again with only vital signs and a mental status examination. Respondent reordered labs again and refilled her medications similar to her previous visit at the same dosages, except he discontinued the Norco and started prescribing Percocet 10/325 mg at 90 per month.[10] Respondent noted in Patient 1's medical record on this date that she "would like to try something different, plus she is complaining of tinnitus...she would like to avoid acetaminophen." On or about January 3, 2017, Respondent printed Patient 1's CURES report.

47. During the July 8, 2021 interview, Respondent was asked about Patient 1 taking some old oxycodone based on the January 2017 visit, to which Respondent stated "she was still trying to titrate to an effective dose" and further stated that he did not believe at that time that Patient 1 had an opioid use disorder.

48. On or about January 17, 2017, Respondent received a facsimile from Patient 1's medical insurance company, Blue Shield of California, advising Respondent that the methadone HCL 10 mg tablet prescribed to Patient 1 was not a covered benefit.

49. On or about February 2, 2017, Patient 1 was seen by Respondent and she reported "I'm feeling better. Taking two instead of one helps more." Respondent performed an examination and assessment similar to the previous visits, except Respondent recorded no blood

[9] This equates to an increase of Patient 1's MME to approximately 990 mg per day.
[10] This equates to an increase of Patient 1's MME to approximately 1,035 mg per day.

pressure in Patient 1's record. Respondent refilled Patient 1's medications similar to her previous visit at the same dosages, with the exception of changing Percocet to oxycodone at 20 mg for 90 tablets per month.[11]

50. On or about March 2, 2017, Respondent refilled Patient 1's medications by telephone and on March 17, 2012 he printed Patient 1's CURES reports.

51. On or about April 4, 2017, Patient 1 arrived late to her appointment and was seen by Respondent and she reported having a little more pain than usual, but overall reported that her pain control was better. Patient 1 also reported catching her 17-year-old nephew taking some of her medications. Patient 1 disclosed to Respondent her plan to begin kayaking. Patient 1 still had not completed the previously ordered laboratory studies. Respondent performed an examination and assessment similar to the previous visits without musculoskeletal or cardiovascular examinations, and refilled her medications similar to her previous visit.

52. On or about May 11, 2017, Patient 1 was seen by Respondent and she reported that she spoke with her sister regarding Patient 1's nephew taking her oxycodone. She also reported her pain was better. Respondent performed an examination and assessment similar to the previous visits and refilled her medications; however, there is no indication in Patient 1's medical records of any laboratory results or follow-up from the prior referrals. On or about June 22, 2017, Respondent refilled Patient 1's medications by telephone.

53. On or about June 30, 2017, Respondent received a facsimile letter from Patient 1's medical insurance requesting a review of Patient 1's narcotic analgesic prescriptions. The letter stated "our prescription claims history indicates your patient is using these prescription drugs in a manner inconsistent with safe or appropriate use as described in the drug package label, FDA guidance, and/or consensus guidelines."[12] There are notations encouraging referral to a pain specialist in patients requiring ongoing narcotic analgesics, and a note that high-dose opioids will not eliminate all chronic pain and will increase the risk of adverse effects and hyperalgesia. The

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[11] This equates to an increase of Patient 1's MME to approximately 1,080 mg per day.

[12] Attached to the letter facsimile is a portion of Patient 1's CURES report from 2016 through June 2017 identifying Respondent's prescribed medications to Patient 1 consisting of methadone HCL, oxycodone HCL, Norco, Ambien, and Percocet.

letter also expressed concern that the patient was taking the opioids in combination with a sedative/hypnotic.

54. Patient 1 missed her appointment with Respondent on or about July 26, 2017, but was seen by Respondent the following day. Patient 1 reported her hair was falling out, that the oxycodone made her feel tired and did not adjust her pain level so she had stopped taking it, and she was feeling uncomfortable and exhausted. Respondent noted discussing Patient 1's insurance company letter with Patient 1. Respondent performed an examination and assessment similar to the previous visits, except Respondent recorded no blood pressure in Patient 1's record. Respondent reordered labs which had yet to be done in the prior year, and refilled her medications similar to her previous visit. However, Respondent discontinued oxycodone and switched Patient 1 to hydrocodone with acetaminophen, in addition to the 240 tablets per month of methadone.[13] Respondent ordered a urine toxicology screening, which was positive for methadone and oxycodone, as well as their metabolites, and negative for benzodiazepines and amphetamines.

55. Patient 1 missed her appointment with Respondent on or about August 25, 2017 due to the death of her mother. Respondent refilled Patient 1's medications by telephone on or about the same day.

56. On or about September 21, 2017, Patient 1 was seen by Respondent and she reported that she began smoking again, that her pain was "bad," that she had previously fallen down, that her hair was still falling out, and that she needed hip surgery even though she had yet to complete the ordered laboratory studies. Respondent performed an examination and assessment similar to the previous visits and noted that her blood pressure was 91/47. Respondent reordered labs again and refilled Patient 1's medications similar to her previous visit, including levothyroxine; 240 methadone at 10 mg; 135 hydrocodone/acetaminophen at 10/325 mg; and 30 Ambien ER at 12.5 mg. On or about the same day, Respondent printed Patient 1's CURES report.

57. Patient 1 missed her next appointment with Respondent on or about October 26, 2017, but was seen by Respondent on or about November 2, 2017. Patient 1's chart notes

[13] Patient 1's CURES report for this time states that she filled 30 tablets of zolpidem at 12.5 mg; 135 tablets of Norco 10/325 mg; and 240 tablets of methadone at 10 mg, which equates to an increase of Patient 1's MME to approximately 1,095 mg per day.

indicated that Patient 1 missed two appointments in the interim. Patient 1 reported feeling distraught and depressed due to repeatedly getting lost on the way to her appointment on this date, subsequently arriving 30 minutes late. She also reported stopping her Wellbutrin and that the high dose had made her jittery. Respondent performed an examination and assessment similar to the previous visits and noted Patient 1 continued smoking. Respondent refilled Patient 1's medications similar to her previous visit, but decreased her total Wellbutrin dose to XL 150 mg per day and added Abilify at 5 mg once per day.

58. During the July 8, 2021 interview, Respondent was asked about Patient 1 missing appointments and getting lost. Respondent stated that he was concerned she may have some cognitive impairment that "didn't seem likely to be due to her pain medication" but had personality pathology. Respondent never referred Patient 1 for an evaluation for possible dementia or other cognitive impairment.

59. On or about November 30, 2017, Patient 1 was seen by Respondent and she reported that she was feeling better despite not sleeping well, and reported her pain as a 6 out of 10. She also reported forgetting to begin the Abilify following the prior visit and she had just started it a few days prior. Patient 1 still had not completed the previously ordered laboratory studies. Respondent performed an examination and assessment similar to the previous visits, without examining Patient 1's hips, heart or extremities, and noted that her blood pressure was 107/69. Respondent refilled her medications similar to her previous visit, while changing her atenolol/chlorthalidone to chlorthalidone alone 25 mg one per day, "as her BP has been low but she gets swollen ankles if she stops the medication."

60. On or about December 28, 2017, Patient 1 was seen by Respondent and she reported that her pain was stable. Respondent performed an examination and assessment similar to the previous visits, without examining Patient 1's lungs, heart or extremities, and noted that her blood pressure was 149/98. Respondent reordered labs again and refilled Patient 1's medications similar to her previous visit at the same dosages, while increasing the Abilify from 5 mg to 10 mg.

61. Patient 1 missed her next appointment with Respondent on or about January 30, 2018, and was 15 minutes late to the following appointment with Respondent on or about February 15, 2018. Consequently, Patient 1 was not seen on that date either.[14]

62. On or about February 15, 2018, Patient 1 had her laboratory studies completed, which were significant for HDL of 32, normal renal and hepatic function, hemoglobin A1c of 6.0%, TSH of 22mIU/L (normal 1-4), WBC 11.2 with elevated neutrophils, low FSH and LH, LDL 80, and low vitamin D of 12 ng/mL.

63. On or about April 13, 2018, Patient 1 called Respondent and stated that she would be late to her appointment and consequently her appointment was rescheduled for later that day. When Patient 1 arrived, she went to the bathroom for an extended period of time. Patient 1 reported that her pain level had been "pretty high," that she was having swelling in her legs, which limited her walking distance, and that she had stopped taking Abilify. Respondent performed an examination and assessment similar to the previous visits and noted Patient 1 reported feeling depressed and sad and that she didn't "want to do anything." Respondent increased Patient 1's thyroid medication, refilled her other medications, started her on vitamin D supplementation, ordered a chest x-ray, and advised her to re-check the thyroid level in 4-5 weeks. There is no indication in Patient 1's medical records that Respondent addressed the pre-diabetes or elevated white blood cell count in Patient 1's February 15, 2018 laboratory studies. Respondent did make the notation in Patient 1's record that her low thyroid was likely "contributing to fluid in your lungs making it hard to breathe;" however, no lung or cardiovascular examination is documented in Patient 1's medical records. On or about the same day, Respondent printed Patient 1's CURES report.

64. Patient 1 missed her next appointment with Respondent on or about May 18, 2018, and reported to Respondent that she was going to the hospital because she "thought maybe she has pneumonia and might have had a stroke." Patient 1 also missed her subsequent appointment on or about May 22, 2018, and her chart notes that she never picked up the methadone and

[14] Per Patient 1's CURES report, she refilled her methadone and Norco prescriptions on January 5, 2018 and again on March 2, 2018. The only controlled substance filled in February 2018 was Ambien.

hydrocodone prescriptions Respondent refilled from May 18, 2018. On or about May 24, 2018, Patient 1 contacted Respondent requesting refills of her prescription medications.

65. On or about May 22, 2018, Patient 1 was arrested for driving under the influence (DUI), being under the influence of narcotics, and possession of controlled substances by the Rancho Cordova Police Department[15] in violation of California Vehicle Code section 23152, subdivision (f), and Health and Safety Code sections 11550 and 11350. Patient 1 hit another vehicle at a slow speed while in an altered state. The police officers at the scene noted she had slow and slurred speech, kept nodding off, her eyes were droopy, and pupils were constricted. The police officers found hydrocodone, oxycodone, tramadol, methadone and, a herpes medication in the vehicle. Patient 1 stated that the tramadol was her deceased mother's and that she used the medication for herself every once in a while. During the July 8, 2021 interview, Respondent stated that Patient 1 informed him of the DUI on May 29, 2018 but claimed he was not aware that she was taking her mother's tramadol.

66. On or about June 5, 2018, Respondent ordered a chest X-ray of Patient 1 which revealed an opacity in the right upper lobe, right lower lobe infiltrate with effusion, ovoid opacity in the right lung base, vascular congestion, and peri-bronchial thickening. Respondent also ordered an MRI of the brain, which revealed a non-specific white matter disease. Laboratory studies done on or about June 2, 2018 revealed a TSH of 38 mIU/L, normal white cell count, and no anemia. There is no indication in Patient 1's medical records of the X-ray results nor any notation of whether Patient 1 went to the hospital for an evaluation after calling and expressing concern about a possible stroke on or about May 18, 2018.

67. On or about June 19, 2018, Patient 1 was seen by Respondent for a physical and she reported having worsening pain, which was now also in her back. She continued to feel congestion with deep breathing, trouble breathing when lying flat, episodes of breathlessness, and felt like her health had deteriorated in the last six months. Respondent performed an examination, which was significant for blood pressure at 124/77 with an elevated pulse of 118 bpm. Respondent also performed a mental status examination and for the first time a physical

[15] Rancho Cordova Police Department Case Report #18-171548.

examination, which was significant for clear lungs to auscultation with fullness in the right base with percussion. Patient 1 had a 3 out of 5 systolic murmur on her heart exam and had bilateral lower extremity edema 4+ to just below the knee with palpable pulses. Patient 1's neurologic exam was grossly normal and her pelvic examination was deferred. There is no indication in the medical records of a musculoskeletal examination being performed, other than Respondent noting a limited range of motion in Patient 1's neck and the patient reporting "I can hear a lot of crunching." Respondent's assessment was similar to previous visits and he continued her medications, ordered an echocardiogram, prescribed azithromycin antibiotic for 5 days, referred her to an orthopedic surgeon, and advised her to repeat her chest X-ray. Respondent noted in the medical records "consider starting slow taper after Ortho consult," and noted stopping tramadol and switching back to Norco for breakthrough pain as the tramadol was ineffective.[16] There is no indication in Patient 1's medical records that Respondent discussed other screening measures such as breast or colon cancer screening, lung cancer screening, vaccinations, or Hepatitis C screening, nor did he offer any diagnosis or intervention for the significant edema discovered in June 2018.

68. On or about July 17, 2018, Patient 1 was admitted to the hospital for frequent falls and shortness of breath. According to the history and physical notes, Patient 1 had an episode approximately eleven days prior when her friend found her at home with a bump on her head and two black eyes. Patient 1 was complaining of a lot of hip pain at the time and had fallen and hit her head. Blood work at that time was significant for extremely low sodium, low albumin, normal liver function tests, and TSH 5.85. Patient 1 had an elevated white blood cell count and was admitted for the shortness of breath, which was presumed to be due to fluid overload. She was treated with antibiotics and the diuretic Lasix. Respondent partially received these medical records on or about August 8, 2018 and was in communication with Patient 1 via email during this time. The hospital physicians recommended discontinuing methadone permanently, and on day seven of Patient 1's hospital stay, methadone was discontinued and her pain was controlled with hydrocodone alone.

[16] There is no indication in Patient 1's 2018 CURES reports of being prescribed tramadol.

69. On or about August 14, 2018, Patient 1 was seen by Respondent and she reported merely slipping and falling on a piece of paper that resulted in her July 17, 2018 hospital admission. She stated the pain was excruciating but now she was "back to normal." She had decided it was time for hip replacement and wanted a referral. She also reported starting back on methadone a few days prior. Respondent noted in Patient 1's medical records that he received only fragments of her discharge summary from her July 2018 hospitalization, but that Patient 1 was told she had "unspecified psychosis" and may have had delirium due to the low sodium. Respondent performed an examination, which included vital signs significant for blood pressure 119/77 and an elevated pulse of 119 bpm. Patient 1's mental status was essentially normal. Respondent's assessment was similar to prior visits and he did not include any of the new diagnoses from the July 2018 hospital stay. Respondent continued Patient 1's levothyroxine at 300 mg; chlorthalidone; trazodone; estradiol patch; 210 methadone at 10 mg; 90 Vicodin at 10/325 mg; 30 Ambien at 12.5 mg; Wellbutrin XL 150 mg; omeprazole; and sertraline at 100 mg. On or about August 23, 2018, Respondent refilled Patient 1's prescribed medication via telephone at dosages similar to prior to her July 2018 hospital stay.[17]

70. Patient 1 missed her next appointment with Respondent on or about September 11, 2018, but was seen by Respondent on or about September 20, 2018. Patient 1 presented in a wheelchair and reported that she was having excruciating pain and was taking the "full dose" of her medications. She stated that the hospital wanted her to have her heart further evaluated and told Respondent that "the hospital wanted her to 'get a heart thing done to check it out.'" Respondent performed an examination, which was significant for a blood pressure reading elevated at 151/98, with pulse of 112 bpm. Besides conducting a mental status exam, which noted the patient was in the wheelchair and otherwise normal, no further examinations were done. Respondent ordered laboratory studies, renewed all of Patient 1's medications at the same doses as prior to the hospitalization, refilled her methadone and Norco, and ordered repeat lab studies. There is no indication in the medical records of any further cardiac or pulmonary evaluations.

[17] Review of Patient 1's CURES report printed by the Respondent on August 14, 2018 demonstrates Patient 1 received Methadone and Norco prescriptions on June 1, 2018 and July 18, 2018 (while she was hospitalized) and again on September 20, 2018.

Patient 1 missed her subsequently scheduled appointment with Respondent on or about October 18, 2018.

71. On or about September 20, 2018, Respondent authored a letter to the pharmacist stating that Patient 1 had been seen in his practice since March 2016 and that she is a candidate for hip replacement surgery. The letter notes Patient 1 was reluctant to have surgery for years and was "able to maintain her quality of life for opioid pain management." Respondent planned to continue to manage her pain with the methadone and Norco until she could receive hip replacement surgery. Respondent stated he monitored his patients who received opioids closely and has extensive experience using methadone in treating both opioid misuse and dependence. Respondent noted that Patient 1's treatment was medically necessary to preserve the patient's health and ability to function.

72. On or about November 9, 2018, Patient 1 died at the age of 60 years old. The Coroner's Report noted she was found deceased in her home with approximately thirty-two (32) prescription medication bottles near her and in the room. The toxicology screening of Patient 1 revealed caffeine, zolpidem, trazodone and metabolites of trazodone, bupropion, and sertraline in her serum. The final cause of death was determined to be Coronary Artery Atherosclerosis and Cardiomegaly.

Patient 2

73. Patient 2, a 32-year-old female patient, who Respondent initially treated at the Bi-Valley Medical Clinic and thereafter, first presented to his private practice on or about September 28, 2016. At the time, Patient 2 was on methadone for opioid use disorder and not pain management. Patient 2 had been seeing a psychiatrist and had recently been diagnosed with cervical and uterine cancer, as well as an abdominal hernia. Patient 2 had a long history of anxiety, PTSD, and had been on the benzodiazepine Klonopin. She had a traumatic childhood with her father being a methamphetamine dealer while her mother was an alcoholic. Patient 2 began taking Vicodin at age 18 for scoliosis and reported currently taking 105 mg per day of methadone, via a methadone clinic, while trying to taper by 10 mg every two weeks. She also reported being a rapid metabolizer and she had been on upwards of 450 mg of methadone per day

in the past. Patient 2 also reported being on gabapentin and other prescription medications that included clonazepam at 2 mg three per day and gabapentin 300 mg three per day. Respondent performed a physical examination of Patient 2, which included normal vital signs and an extensive mental status examination. Respondent diagnosed Patient 2 with PTSD, anxiety, depression, opioid dependence in long-term full remission on methadone, and cervical and endometrial cancer. Respondent prescribed 90 tablets of clonazepam at 2 mg, one tablet three times per day; 90 tablets of gabapentin at 300 mg, one tablet three times a day; and 30 tablets of duloxetine at 30 mg, one tablet nightly. On or about October 27, 2016, Respondent printed a CURES report for Patient 2 which demonstrated Patient 2 received 30 tablets of Norco at 10/325 mg per month from another physician in May, June, August, September and October of 2016, as well as 90 tablets of clonazepam at 2 mg from Respondent per month. The CURES reports also evidenced Patient 2 received 150 tablets of oxycodone at 10 mg from her oncologist on October 19, 2016.

74. On or about October 27, 2016, Patient 2 was seen by Respondent and presented using a walker due to having been recently hospitalized for a hysterectomy and hernia repair. She reported a pain level of 8 out of 10 and was on hydrocodone 10 mg, twice a day, as well as oxycodone 10 mg, 2-4 tablets every 4 hours from her gynecologic oncologist. Patient 2 reported being on hydromorphone, ketamine, and oxycodone during her hospital stay. She also reported that the hospital physicians wanted to increase her methadone from 80 mg to 120 mg but she refused. Respondent performed a physical examination of Patient 2 including normal vital signs and an extensive mental status exam with no other physical. Respondent's assessment of Patient 2 included "PTSD, anxiety, depression, opioid dependence and long-term full remission on methadone, cervical and endometrial cancer likely Stage I now postop from hysterectomy and hernia repair, ovaries intact." Respondent refilled Patient 2's clonazepam and gabapentin and increased her duloxetine to 60 mg, and noted that Patient 2's other physician "seems uncomfortable continuing [the hydrocodone]," but the patient felt it was helping even though she was already on high-dose oxycodone and her surgeon was managing her post-operative pain at that time.

75. On or about November 4, 2016, Respondent received a facsimile from Patient 2's oncologist describing her surgical and post-operative course. The facsimile included notations that Patient 2 had chronic pelvic pain, a history of chronic back pain from scoliosis, and history of "opioid addiction." She was discharged on methadone at 90 mg daily; Tylenol; gabapentin at 300 mg, three times a day; ibuprofen at 800 mg, three times a day; and oxycodone at 10 mg, 2-4 tablets every 4 hours. Her physical examination at the follow-up visit on October 26, 2016 with a mid-level of her oncologist was essentially normal, and the provider noted "pain was not unanticipated and will continue to improve over the following weeks."

76. Patient 2 was treated by Respondent until her death on August 18, 2019. Patient 2's death was due to respiratory failure, pulmonary hypertension, and metastatic carcinoma of the lung with history of uterine cancer at the age of 35 years old. A review of Patient 2's CURES reports from November 2016 through August 2019 evidence Respondent prescribing 180 tablets of 30 mg oxycodone on or about November 10, December 2, and December 29 of 2016.[18] On or about January 16, 2017 and then monthly through April 2018, that oxycodone prescription rose to 210 tablets per month.[19] From May 2018 through August 2019 Patient 2's oxycodone prescription from Respondent went back to 180 tablets per month. Simultaneously, Respondent prescribed Patient 2 60 tablets per month of MS Contin at 60 mg from December 2016 through August 2019;[20] 90 tablets per month of clonazepam at 2 mg from November 2016 through August 2019 for anxiety; and 120 tablets per month of Norco at 10/325 mg on or about November 22, 2016. This equates to an approximate MME of 390 to 435 mg per day from November 2016 through August 2019, not including Patient 2's methadone which was not indicated on Patient 2's CURES reports when it was dispensed by the Methadone clinic.[21] During the July 8, 2021 interview, Respondent stated that he did not significantly taper Patient 2's medications because she "continued to have severe pain." Patient 2's records do not indicate Respondent

[18] This equates to approximately MME 270 mg per day.
[19] This equates to approximately MME 315 mg per day.
[20] This equates to approximately MME 120 mg per day.
[21] If Patient 2 was on approximately 110 mg of methadone as reported in her medical notes, this would equate to an additional 1,000-1,300 MME per day of opioids.

recommended alternatives or adjuncts to these opioid prescriptions, even when Patient 2 asked to be switched to the safer alternative Suboxone on or about April 21, 2017.

77. On or about November 10, 2016, Respondent printed Patient 2's CURES report which demonstrated the prior oxycodone refill from Patient 2's oncologist was on October 19, 2016 for 150 tablets per month of hydrocodone at 10 mg, and prior to that, Patient 2 only had 60 tablets of hydrocodone at 10 mg per month. This denotes an increase from 20 MME per day while on the hydrocodone, to 75 MME per day while on the 10 mg oxycodone from Patient 2's oncologist, to 270 MME per day while on the 30 mg of oxycodone from Respondent. Another CURES report was printed by Respondent on November 22, 2016 that demonstrated Patient 2 received 100 tablets of oxycodone 10 mg prescriptions from her oncologist on November 8, 2016 and 150 tablets on November 3, 2016.

78. Subsequent to Patient 2's hospitalization for her hysterectomy and hernia repair, Respondent prescribed high-dose opioids for the patient for post-operative pain, and never once documented a pelvic or abdominal physical examination other than noting occasional distention in Patient 2's medical records. Respondent ordered an ultrasound in May 2017 which was normal, and an MRI which was never completed. Other than the November 4, 2016 facsimile Respondent received after Patient 2's surgery, there is no documentation that Respondent communicated with the patient's gynecology or gastroenterology specialists, nor obtained further medical records.

79. While Respondent prescribed 90 tablets of clonazepam at 2 mg per month from November 2016 through August 2019, Respondent also prescribed combinations of gabapentin and multiple opioids such as methadone, oxycodone, MS Contin and Norco, without reducing Patient 2's benzodiazepine dosage or indicating in Patient 2's records consideration of a safer alternative.

80. On or about March 14, 2017, Patient 2 was seen by Respondent and reported going to the methadone clinic and obtaining 30 days of daily dosing of methadone. At that visit, Respondent had Patient 2 sign a consent page titled "Opiates and Benzodiazepines: Lethal interaction" regarding the dangers of combining painkillers and anti-anxiety drugs.

81. During the period of September 28, 2016 to June 7, 2019, Respondent saw Patient 2 for monthly follow-up visits, where Patient 2 missed appointments in December 2016 and February 2017. At these visits, Respondent documented identical physical examinations that included only findings as to Patient 2's vital signs and mental status. These physical examinations did not document detailed descriptions of where Patient 2's pain was located, the severity of the pain, or a demonstrable worsening of Patient 2's disease that would dictate a continued period of increased MME's.

82. During the period of September 28, 2016 to June 7, 2019, Respondent's assessments of Patient 2 in the medical records remained similar to the initial September 28, 2016 visit, with the exceptions of November 22, 2016, when Respondent added that Patient 2 was "having severe pain in other postop problems; still followed by UCSF surgeon but I am managing her opioids," and on May 8, 2018, when Respondent added "we're beginning taper of pain medication May 2018," followed by Respondent decreasing her oxycodone quantity from 210 per month to 180 tablets per month.

83. During the period of September 28, 2016 to June 7, 2019, Patient 2's medical records also do not indicate any direct communication between Respondent and any of Patient 2's other medical providers or the methadone clinic Patient 2 frequented. Nor did Respondent consistently track Patient 2's methadone intake in her medical records from the methadone clinic despite Patient 2's record indicating she was still taking methadone between September 2016 and June 2019,[22] or that she claimed she tested positive for amphetamines at the clinic in May 2018.

84. On or about September 4, 2018, Respondent authored a letter to a pharmacist stating that Patient 2 was being seen at the methadone clinic weekly.

85. During the July 8, 2021 interview, Respondent stated he knew that the methadone clinic was doing routine testing and they would "let him know" if there were any aberrancies; however, there is no indication in Patient 2's medical records whether Respondent corroborated whether Patient 2 was actually still being seen at the methadone clinic, and there is no

[22] During Patient 2's visit with Respondent on or about August 22, 2018, Patient 2 was seen by Respondent and reported she was continually being seen at the Methadone clinic and was taking 105 mg of methadone per day at the time; equivalent to over 1,000 MME per day.

documentation that Respondent was notified when Patient 2 reportedly tested positive for amphetamines on May 8, 2018, other than Patient 2's self-reporting that it was due to Sudafed. There is no indication in Patient 2's medical records that Respondent ever ordered a urine toxicology screening for Patient 2 at any time.

Patient 3

86. Patient 3, a 73-year-old male, had a prior documented history of PTSD, hyperlipidemia, hypertension, phlebitis, GERD, thoracic disc disease, obesity hypoventilation syndrome, anxiety, chronic pain, history of osteomyelitis, insomnia, and panic attacks prior to becoming Respondent's patient on or about January 19, 2016. He had also previously undergone surgeries that included a tonsillectomy and prior sigmoidoscopy. Patient 3 had been prescribed aspirin, alendronate (Fosamax), escitalopram (Lexapro),[23] hydrocodone with acetaminophen (Norco) at 10/325 mg, Lidoderm patches, lisinopril at 5 mg, lorazepam (Ativan) at 1 mg, pantoprazole (Protonix), and pravastatin. During the July 8, 2021 interview, Respondent stated that he was unaware of Patient 3's diagnosis of obesity hypoventilation syndrome and did not recall if Patient 3 was using a continuous positive airway pressure (CPAP) machine.

87. On or about January 19, 2016, Patient 3 was initially seen by Respondent and he reported taking 4 mg of lorazepam for panic attacks and hydrocodone for daily pain. He stated no one had ever discussed with him the risk of respiratory depression with his medications, especially the combination of benzodiazepines and opioids. He reported low energy and trouble concentrating with some suicidal thoughts. Patient 3 also reported being on trazodone and Ambien in the past with poor results. Past medical history was reported as obesity and leg venous insufficiency. Respondent performed an examination of Patient 3, which was significant for the absence of vital signs or other physical details other than a detailed mental status examination. Respondent's assessment of Patient 3 was PTSD with severe chronic pain following osteomyelitis of his right foot, and ankle, and spine. Respondent prescribed 120 tablets of lorazepam at 2 mg

[23] Lexapro (escitalopram) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Escitalopram affects chemicals in the brain that may be unbalanced in people with depression or anxiety.

(8mg per day), 240 tablets of Norco at 10/325 mg, and 60 tablets of MS Contin 30 mg 1 tablet twice a day.[24] Respondent also documented an extensive discussion regarding the risks of opioids, including respiratory depression, and his plan was to have the patient on a scheduled benzodiazepine dosing "time to coincide last toxically with opioid dosing." On the same day, Respondent printed Patient 3's CURES report that demonstrated Patient 3 was receiving 240 tablets of Norco at 10/325 mg, as well as 120 tablets of lorazepam at 1 mg, from a previous medical provider.[25]

88. On or about January 20, 2016, Respondent sent Patient 3 a lengthy email message which stated that the medications were risky and included a high potential for death. Respondent also noted that "I also have a hidden, selfish agenda which is to make sure that I treat you in a way that makes it apparent to regulators that we are all acting in good faith to treat your medical condition, not feeding an underground drug market." Respondent recommended starting the MS Contin and prescribed the full dose of Norco "because I do not want you to have to deal with anxiety around what will happen if you do not tolerate the MS Contin or it is too expensive or anything like that." Respondent recommended taking the MS Contin doses 12 hours apart, the lorazepam doses about 8 hours apart, and to "work out a schedule that puts 2 hours between MS Contin doses and lorazepam doses."

89. On or about March 2, 2016, Patient 3 was seen by Respondent and he reported "my pain is fine... I do not really have joint pain complaints" and that he was taking approximately 5 hydrocodone per day, in addition to the MS Contin. Patient 3's wife reported to Respondent that she was concerned that the morphine dosage was too high and that Patient 3 seemed more confused and had an episode where he got his pills mixed up. Respondent performed a physical exam of Patient 3 which was notable for a blood pressure reading 133/82 and a BMI of 41. Again, there was no physical examination other than a detailed mental status exam. Respondent's assessment was identical to the previous visits and Respondent prescribed 120 tablets of

[24] This equates to approximately MME 140 mg per day.
[25] This equates to approximately MME 80 mg per day.

lorazepam at 2 mg, 180 tablets of Norco, and 60 tablets of MS Contin, which he increased from 30 mg to 60 mg/tab.[26]

90. On or about April 21, 2016, Patient 3 was seen by Respondent and he reported less pain and he stated he wanted to continue the current dose for another month prior to dropping the Norco. Patient 3 also reported not sleeping well and the he had taken Ambien in the past but had some paranoia with it previously. He also reported taking trazodone in the past. Respondent performed a physical exam of Patient 3, which was significant for an elevated blood pressure reading 152/80 and a BMI that was down to 39. There was no other physical examination noted other than vital signs. Respondent's assessment included the statement "his overall level of function and overall opioid dose both seem to be improving with rational pain management." Respondent renewed the similar controlled substances at the same doses as the previous visit and added oral trazodone at 50 mg at night for insomnia.

91. On or about May 19, 2016, Patient 3 was seen by Respondent and he reported taking two trazodone for sleep and also using it as needed for anxiety attacks. Patient 3 did not think he could function at all without his medication. Respondent performed a physical examination of Patient 3 which included only vital signs and a mental status exam. Respondent's assessment was repeated verbatim from the prior visit. Respondent continued the same controlled substance regimen as before, increased the trazodone to 100 mg, and advised Patient 3 to continue the lorazepam "separating doses from opioids." A drug test was performed on that date, which was positive for hydrocodone, morphine, and lorazepam.

92. On or about July 14, 2016, Patient 3 was seen by Respondent and he reported he was doing well but he was sleeping a lot. Respondent performed a physical examination of Patient 3 where vital signs were noted, as well as an extensive mental status exam. Respondent's assessment was repeated verbatim from the prior visit. Respondent refilled Patient 3's 120 tablets of lorazepam with 2 refills and gave 3 prescriptions each of 180 tablets of Norco at 10 mg and 60 tablets of MS Contin at 60 mg.

[26] This equates to approximately MME 180 mg per day.

93. On or about September 8, 2016, Patient 3 was seen by Respondent and presented with bilateral black eyes and a bandage on his nose reporting that he "got his foot under a throw rug and fell." He also reported his pain management was "good" but he still had some anxiety in addition to some incontinence issues. Patient 3's wife reported to Respondent that Patient 3 was having more difficulty with balance. Respondent performed a physical examination of Patient 3 where his vital signs were normal, other than a BMI of 38, and a mental status exam was again noted. Respondent documented an "abbreviated neuro exam was notable for mild to moderate cogwheel rigidity in the upper extremity with distraction." Respondent's assessment was repeated from Patient 3's prior visits. Respondent refilled Patient 3's lorazepam, Norco, trazodone, and MS Contin which were continued at the same dosages and refilled for two months.

94. On or about December 1, 2016, Patient 3 was seen by Respondent and reported he was on antibiotics due to an infection in his leg and had undergone an MRI which "showed some deterioration." Patient 3 also reported being placed on donepezil (Aricept; typically used for dementia) but got a rash so he stopped it. Respondent performed a physical examination of Patient 3 where his vital signs were normal and a mental status exam was noted. Respondent's assessment was repeated again verbatim from prior visits and Patient 3's medications were again refilled at the same dosages for 3 months. There was no other discussion regarding the neurology visit and no consultation notes included in Patient 3's medical record.

95. On or about February 23, 2017, Patient 3 was seen by Respondent and reported doing well and that his memory "is about where it has been." Respondent performed a physical examination of Patient 3 where his vital signs were noted and his BMI was 37. Patient's 3 mental status exam was again extensive with no other physical examination. Respondent's assessment was repeated verbatim and the medications again refilled for 3 months at the same dosages. There was a signed consent titled "opiates and benzodiazepines: Lethal interaction" which delineated the black box warning and concerns about respiratory depression with the combination of benzodiazepines and opioids signed by the patient on that date.

96. On or about May 16, 2017, Patient 3 was last seen by Respondent where Respondent performed a physical examination of Patient 3 that was unremarkable other than an elevated

blood pressure of 151/86. Respondent refilled Patient 3's medications again at the same dosages for three months. Patient 3's medical records included a chart notation from a provider at UC Davis Health system, dated August 8, 2017. At this visit, his pulse ox was 80% and his pulse was 103 bpm and there was a notation to stop his lorazepam and to follow-up in 2018.

97. On or about August 20, 2017, Respondent received an email message from Patient 3's wife stating that Patient 3 took some medication the previous night and never woke up. Patient 3 died on August 19, 2017 at the age of 74. The cause of death listed on Patient 3's Death Certificate was Acute Hypoxic Respiratory Failure, long-acting morphine and benzodiazepine narcotic overdose, and methicillin resistant staphylococcus aureus bacterial infection-etiology unknown. Under the other significant conditions contributing to Patient 3's death listed on his Death Certificate were end stage Alzheimer's disease, morbid obesity, and chronic pain.

98. A review of Patient 3's CURES reports from January 2016 through August 2017 evidence Respondent prescribing 180 tablets per month of Norco at 10/325 mg from March 2016 through August 2017,[27] 60 tablets per month of MS Contin at 60 mg from March 2016 through August 2017,[28] and 120 tablets per month of lorazepam at 2 mg from March 2016 through August 2017. CURES reports printed at each of the visits with Respondent demonstrated Respondent was the only prescriber of any controlled substances during this time period. There is no indication in Patient 3's medical records of any X-rays, laboratory reports, or other consultations or referrals, other than the two noted above.

Patient 4

99. Patient 4, a 29-year-old male patient, first presented and was treated by Respondent in May 2011[29] until his death in August 2017. Patient 4 had a medical history significant for traumatic brain injury, bipolar disorder, panic disorder, frontal disinhibition, and chronic pain following a motorcycle accident. When Patient 4 was seen by Respondent on or about December

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[27] This equates to approximately MME 60 mg per day.

[28] This equates to approximately MME 120 mg per day.

[29] Conduct alleged to have occurred before October 4, 2014, is for informational purposes only. That said, errors or omissions that occurred before October 4, 2014, which led to a continuing course of conduct that resulted in errors and omissions after October 4, 2014, are being alleged as a basis for discipline.

15, 2011, he reported feeling decent and was taking Seroquel (quetiapine) and clonazepam while continuing to have anxiety attacks, and was taking MS Contin while reporting his pain level was around a 7.5 out of 10. Respondent's physical examination of Patient 4 included only normal vital signs and an extensive mental status exam. Respondent's assessment noted "a pleasant young man with chronic pain following a motorcycle accident, bipolar disorder, and anxiety, endorsing a history of ADHD. Markedly improved from an acute manic episode after starting high-dose Seroquel." Respondent noted in the problem list of Patient 4's medical record as having "chronic shoulder, neck, and back pain; bipolar moods, anxiety." Respondent renewed Patient 4's prescriptions for 300 tablets of Seroquel XR 300 mg 2 for 1 year, 90 tablets of Norco at 10/325 mg, 60 tablets of MS Contin at 60 mg 1 every 12 hours, and 60 tablets of clonazepam at 2 mg 1 twice daily.[30]

100. A review of Patient 4's medical records from on or about February 2012 through March 2012 evidence Respondent refilling Patient 4's medications while increasing Patient 4's prescription for MS Contin from 120 mg per day to 150 mg, increasing his clonazepam from 60 tablets per month to 65, and adding omeprazole and ibuprofen 800 mg 3 times a day for 10 days. On or about March 8, 2012, Respondent began prescribing 60 tablets of alprazolam per month in addition to the Seroquel, decreased the MS Contin to 120 mg per day, and continued the Norco while discontinuing the ibuprofen and omeprazole.

101. A review of Patient 4's medical records from on or about September 13, 2012 and continuing through November 2013, indicate that Respondent added Lamictal to the Seroquel; prescribed 70 tablets per month of Norco at 10/325 mg, which was increased to 90 tablets in November 2012; prescribed 120 tablets per month of alprazolam at 2 mg; and prescribed 90 tablets per month of MS Contin at 60 mg.[31]

102. A review of Patient 4's medical records from on or about December 13, 2013 and continuing through February 2014, indicate that Respondent prescribed 90 tablets per month of alprazolam at 2 mg; 900 mg of Seroquel per day; 60 tablets per month of MS Contin at 30 mg,

[30] This equates to approximately MME 150 mg per day.
[31] This equates to approximately a total of MME 210 mg per day.

which was increased to 60 mg on or about January 2, 2014; and started prescribing 180 tablets per month of oxycodone at 5 mg. On or about March 6, 2014, Respondent also began prescribing Patient 4 60 tablets per month of Ritalin at 5 mg.

103. A review of Patient 4's medical records from on or about May 30, 2014 and continuing through September 2014, indicate that Respondent continued prescribing alprazolam and Seroquel while increasing the Ritalin to 10 mg and prescribing 120 tablets per month of MS Contin at 30 mg. On or about October 31, 2014 and continuing through December 2014, Respondent increased Patient 4's prescription of oxycodone to 80 tablets per month at 30 mg.[32]

104. From on or about December 15, 2011, through October 31, 2014, Respondent saw Patient 4 approximately 18 times, during which Respondent's physical examinations included vital signs and mental status exams with the same or similar assessments as the December 2011 visit without any other physical examinations being documented. However, on or about April 11, 2013, Respondent examined Patient 4's ears, eyes, lymph nodes, and oropharynx, and noted in his assessment "continues to have a high drama presentation with last-minute requests for medication refills that become an emergency, missed appointments and dramatic life events." On or about July 25, 2013, Patient 4 was seen by Respondent where Respondent Patient 4's chronic pain in his assessment. During this same period, Patient 4 missed his appointment on or about March 1, 2012, reported a theft of his medications on or about January 16, 2012, and requested an early refill of his medications on or about November 30, 2012. In January 2012, a urine toxicology screening was ordered but there was no indication of the results in Patient 4's medical records.

105. On at least two occasions, Patient 4 reported to Respondent that he had been incarcerated in jail in August 2013 and again in May 2016 due to an assault.

106. A review of Patient 4's medical records from on or about January 27, 2015 and continuing through September 2015, indicate that Respondent continued Patient 4's prescriptions while increasing his MS Contin to 180 tablets per month at 30 mg in January,[33] substituted the

[32] This equates to approximately a total of MME 240 mg per day.
[33] This equates to approximately a total of MME 300 mg per day.

MS Contin for 15 mg Opana ER at 1 tablet twice daily in July, but switched back to the MS Contin in September.

107. On or about July 6, 2015, Respondent received a facsimile from Patient 4's medical insurance company expressing concern regarding the multiple prescriptions of controlled substances prescribed to Patient 4 by Respondent.

108. On or about October 8, 2015, Patient 4 was seen by Respondent and Respondent continued Patient 4's medication prescriptions and added Wellbutrin XL at 150 mg and lisinopril at 10 mg. On or about October 27, 2015, Patient 4 called Respondent and reported his oxycodone, MS Contin, and alprazolam prescriptions were stolen by his ex-girlfriend. Respondent gave Patient 4 a "tapering prescription..." of 20 tablets oxycodone at 15 mg and 20 tablets of alprazolam at 1 mg. All of Patient 4's medication prescriptions were refilled at full doses via the telephone on or about December 10, 2015.

109. A review of Patient 4's medical records from on or about January 3, 2016 and continuing through May 2017, indicate that Respondent continued Patient 4's prescriptions while substituting the Wellbutrin for 30 mg for duloxetine once a day in March 2016; increasing Patient 4's MS Contin to 100 mg twice daily "for baseline control pain" in June 2016;[34] adding 300 mg of quetiapine per day for "breakthrough anxiety" in September 2016; and increasing Patient 4's oxycodone from 90 to 120 tablets per month in December 2016.[35]

110. On or about May 24, 2017, Patient 4 was last seen by Respondent and he reported attending anger management classes and sustaining a mandibular fracture in a fight. Respondent continued to prescribe Patient 4's medications at the same dosages. There was a signed consent titled "opiates and benzodiazepines: Lethal interaction" signed by the patient on that date. On or about August 3, 017 Patient 4 died at the age of 35 years old due to acute pneumonia and empyema.

111. A review of Patient 4's CURES reports from October 2016 through July 2017 evidence Respondent prescribing 60 tablets per month of MS Contin at 100 mg from November

[34] This equates to approximately a total of MME 335 mg per day.
[35] This equates to approximately MME 380 mg per day.

2016 through July 2017;[36] 90 tablets per month of oxycodone at 30 mg from November 2016 through December 2016;[37] 120 tablets per month of oxycodone at 30 mg from January 2017 through July 2017;[38] 90 tablets per month of alprazolam at 2 mg from November 2016 through July 2017; and 60 tablets per month of methylphenidate at 10 mg from November 2016 through July 2017.

112. From on or about January 27, 2015, through May 24, 2017, Respondent saw Patient 4 approximately 13 times, during which Respondent's physical examinations of Patient 4 included vital signs and mental status exams with the same or similar assessment as the December 2011 visit without any other physical examinations being documented of Patient 4's shoulder, neck or back, other than one examination of Patient 4's stab wound on or about January 3, 2016 and one mention of tender spots on his back on or about July 29, 2015. On or about July 29, 2015, Respondent included in his assessment of Patient 4 "acute psychiatric distress due to conflicts with his father, possibly exacerbated by complicated UTI." Patient 4's medical records also do not indicate if Respondent performed an evaluation such as imaging of Patient 4's shoulder, neck or back; or corroborated with other medical specialists; or contain a clear medical diagnosis necessitating increased dosages of opioids over a period of years.

113. During the July 8, 2021 interview, Respondent stated that Patient 4's pain was caused by chronic shoulder, neck, back, and head pain from a metal plate which required long-term opiates for management. Respondent admitted there was no objective information about the cause of pain in his shoulder, neck, or back, and he did not attempt to wean Patient 4's opioid dosages. Other than one examination of Patient 4's stab wound on or about January 3, 2016 and one mention of tender spots on his back on or about July 29, 2015, there was no indication in Patient 4's medical records of an examination of the patient's shoulder, neck, back, or face between December 2011 and his death in August 2017 by Respondent. Respondent also admitted that he never performed a urine toxicology screening of Patient 4 even though he was prescribing two different opioids, a benzodiazepine, and stimulants to Patient 4.

[36] This equates to approximately MME 200 mg per day.
[37] This equates to approximately MME 135 mg per day.
[38] This equates to approximately MME 180 mg per day.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

114. Respondent Ronald Paul Risley, M.D. has subjected his Physician's and Surgeon's Certificate No. A 63721 to disciplinary action under sections 2227 and 2234, as defined by 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 set forth in paragraphs 31 through 113, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

115. Respondent's license is subject to disciplinary action because he committed gross negligence during the care and treatment of Patients 1, 2, 3, and 4 in the following distinct and separate ways:

a. By prescribing Patient 1 increasing high dosages of methadone and hydrocodone over a two-year period for joint pain without adequate evaluation and medical justification;

b. By failing to adequately treat Patient 1's musculoskeletal pain without an adequate history and physical examination;

c. By prescribing high doses of opioids without adequate evaluation and medical justification to Patient 2, who had a known opioid use disorder for over approximately 18 months;

d. By failing to order any urine toxicology screenings for Patient 2, who was being prescribed three different opioids and a high dose benzodiazepine with a known drug abuse history;

e. By prescribing high doses of opioids without adequate evaluation and medical justification to Patient 3, who had signs and symptoms of sedation, overmedication, and significant comorbidities;

f. By prescribing high doses of opioids without adequate evaluation and medical justification to Patient 4; and

g. By prescribing increasing doses of opioids for Patient 4 without clear medical indication, evaluation, or diagnosis.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

116. Respondent Ronald Paul Risley, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63721 to disciplinary action under sections 2227 and 2234, as defined by 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 as more particularly alleged in paragraphs 31 through 113, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

117. The instances of gross departures from the standard of care as set forth in paragraph 114, are incorporated by reference as if fully set forth herein and serve as repeated negligent acts.

118. Respondent's license is subject to disciplinary action because he committed repeated negligent acts during the care and treatment of Patients 1, 2, 3, and 4 in the following additional distinct and separate ways:

a. By failing to obtain adequate records to determine the hospital course and outcome and making no efforts to ensure Patient 1 had appropriate cardiac follow-up or referral, even after presenting to Respondent with a request and significant cardiac symptoms prior to her hospitalization;

b. By failing to appropriately treat Patient 1's heart failure given her history of multiple cardiac risk factors; being prescribed high dose methadone in combination with diuretics by Respondent; her July 2018 hospitalization; and her ongoing symptoms such as her leg edema, tachycardia, episodes of confusion, and progressive difficulties breathing;

c. By prescribing Patient 1 diuretics and thyroid supplementation (levothyroxine) from March 2016 to February 2018 without obtaining a metabolic panel or TSH level prior to February 2018;

d. By prescribing benzodiazepines in combination with high-dose opioids to Patient 2 who had a known substance use disorder, without indicating in Patient 2's medical records safer alternatives or attempting to minimize the dose;

e. By treating Patient 2's abdominal and pelvic pain without an adequate physical examination;

f. By prescribing benzodiazepines in combination with high-dose opioids without considering safer alternatives or attempting to minimize the dose to Patient 3, who had pulmonary issues and was elderly;

g. By prescribing Patient 3 high-dose opioids without a documented safer alternative for treatment, a clear indication, or diagnosis in the absence of a full physical examination documented, and no evaluation such as imaging or corroboration with other specialists being performed; and

h. By failing to perform and obtain a urine toxicology screening from Patient 4.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

119. Respondent Ronald Paul Risley, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 63721 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he committed incompetence. The circumstances are set forth in paragraphs 31 through 72, and those paragraphs are incorporated by reference and re-alleged as if fully set forth herein.

120. Respondent's license is subject to disciplinary action because he committed incompetence during the care and treatment of Patient 1 in the following distinct and separate ways:

a. By failing to appropriately identify and treat Patient 1's acute episode of heart failure when she had a history of multiple cardiac risk factors and presented with a leg edema, tachycardia, episodes of confusion, and progressive difficulty breathing in June 2018 while Respondent was prescribing her high dose methadone; and

b. By failing to identify Patient 1 had an opioid use disorder given that she took increasingly high dosages of opioids, even when she began to exhibit possible side effects such as feeling "out of it," getting lost, missing appointments, falling, getting a DUI, being more

depressed and less active, admitting to taking her mother's tramadol, taking oxycodone which was not prescribed at the time, and having a physical tolerance to the medications.

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 No. A 63721, issued to Respondent Ronald Paul Risley, M.D.;

2. Revoking, suspending or denying approval of Respondent Ronald Paul Risley, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Ronald Paul Risley, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAR 16 2022

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

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