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

In the Matter of the Accusation Against: **PRAKASHCHANDRA CHHOTABHAI PATEL, M.D.** **395 North San Jacinto Street, Suite B** **Hemet, California 92543** **Physician's and Surgeon's Certificate No. A 32995,** Respondent.	Case No. 800-2019-052747 **A C C U S A T I O N**

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 October 11, 1978, the Board issued Physician's and Surgeon's Certificate Number A 32995 to Prakashchandra Chhotabhai Patel, M.D. ("Respondent"). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2022, 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.

STATUTORY PROVISIONS

5. Section 2234 of the Code (effective from January 1, 2014, to December 31, 2019) 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.
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> (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 practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. Section 2266 of the Code (effective from February 21, 1996, to the Present) 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.

7. Health and Safety Code section 11165.4 (effective from October 2, 2018, to December 31, 2019) states:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5)(A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in

the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies1 that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

DEFINITIONS

8. **Buprenorphine** (Subutex) is an opioid medication. It is used for the long term "medication-assisted treatment" of opioid use disorder or opioid addiction. **Buprenorphine and naloxone** (Suboxone) are also used to treat opiate addiction. Naloxone blocks the effects of opioid medication, including pain relief or feelings of well-being that can lead to opioid abuse. Buprenorphine and all products containing buprenorphine are Schedule III controlled substances as defined by section 1308.13, subdivision (e)(2)(i), of the Code of Federal Regulations.

Buprenorphine is a Schedule V controlled substance as defined by California Health and Safety Code section 11058, subdivision (d). Buprenorphine is a dangerous drug as defined in California Business and Professions Code section 4022.

9. **Hydrocodone/acetaminophen** (Norco, Lortab, Vicodin) is an opioid pain medication. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (b)(1)(vi), of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), and Health and Safety Code section 11165.4, subdivision (a), in that he was grossly negligent in the care and treatment of Patient 1.[1] The circumstances are as follows:

Patient 1

11. From approximately October 5, 2018, to approximately June 6, 2019, Respondent provided psychiatric care and treatment to Patient 1, a then fifty-four-year-old male patient. During that time period, Respondent treated Patient 1 for opioid use disorder.

12. Patient 1 had a history of back pain as a result of being involved in a car accident in approximately 2006. He took Norco 10 mg, up to six tablets daily, for approximately ten years, for his pain. This was followed by at least two years of buprenorphine maintenance. At one time, in approximately 2015, his buprenorphine was discontinued and he experienced severe withdrawal symptoms and depression with suicidal thoughts. On or about September 18, 2018, Patient 1's primary care physician performed laboratory testing on Patient 1. The test results showed Patient 1 was positive only for buprenorphine.

13. When Respondent began treating Patient 1, Respondent continued buprenorphine treatment. However, starting on February 13, 2019, Respondent discussed his recommendation of tapering and stopping the buprenorphine with Patient 1 on several occasions. The taper began

[1] The name of the patient is omitted in order to protect his right of privacy.

on March 14, 2019, when Patient 1 began reducing his buprenorphine treatment from 45 tabs to 40 tabs per month. The taper continued on April 8, 2019, and again on May 8, 2019. Patient 1 was taking 35 tabs instead of 45 tabs. On the final visit, June 6, 2019, Respondent reduced the number of buprenorphine tabs to 30. Patient 1 did not return to see Respondent for care and treatment after that date.

14. Patient 1's prescription records reflect the following buprenorphine prescriptions from Respondent.

A. On or about October 5, 2018; November 2, 2018; December 18, 2018; January 18, 2019; February 13, 2019; and March 14, 2019, Respondent prescribed buprenorphine, 8 mg, 45 tabs, 30 day supply.

B. On or about April 8, 2019, and May 8, 2019, Respondent prescribed buprenorphine, 8 mg, 35 tabs, 28 day supply.

C. On or about June 6, 2019, Respondent prescribed buprenorphine, 8 mg, 30 tabs, 30 day supply.

15. During the time that he treated Patient 1, Respondent failed to order laboratory tests for Patient 1, failed to review Controlled Substance Utilization Review and Evaluation System ("CURES") reports for Patient 1 or document that he reviewed CURES reports for Patient 1, and failed to maintain adequate and accurate records concerning the care and treatment that he provided to Patient 1.

16. Respondent committed the following extreme departures from the standard of care with respect to his care and treatment of Patient 1:

A. Respondent committed an extreme departure from the standard of care by tapering and stopping buprenorphine in a patient with a documented long history of opioid use disorder. Respondent incorrectly tapered to discontinue buprenorphine maintenance treatment for opioid addiction, although Patient 1 was stable. This risked Patient 1 restarting Norco, or other opioids. There is no evidence that Patient 1 was abusing buprenorphine. When a patient is on buprenorphine, the patient is unlikely to use potentially lethal opiates.

B. Respondent committed an extreme departure from the standard of care by failing to

order any laboratory tests in his treatment of a patient with opioid use disorder. He failed to order drug toxicology screens and liver and serology tests to: (1) determine whether the prescribed medication was being diverted, given, or sold to other people; (2) learn of and recognize concurrent or comorbid medical or physical conditions and medications, e.g., liver function tests, hepatitis screening and HIV testing; and (3) learn of concurrent use of other substances of abuse. The failure to order laboratory testing risked missed diagnosis of serious medical conditions and substance abuse. The testing was especially important since Respondent was tapering down Patient 1's dose of buprenorphine, risking that Patient 1 may restart opioids or abuse other substances.

C. Respondent committed an extreme departure from the standard of care by failing to review the information in CURES reports for Patient 1, whom Respondent was treating for an opioid use disorder and prescribing a controlled substance. To meet the standard of care, Respondent was required to review the reports himself and to document that he reviewed the CURES reports. A staff member or other proxy cannot review CURES on a physician's behalf. Respondent's failure to review CURES reports for Patient 1 risked harm to Patient 1 for overdose, as Respondent was unaware if the patient was obtaining narcotics from other providers.

D. Respondent committed an extreme departure from the standard of care by failing to maintain adequate and accurate medical records. Respondent's documentation was deficient, risking his patient's life. The main diagnosis documented in the patient's medical records is undated and unsigned. There is no documentation in the clinical record supporting the quantity and dose of buprenorphine that Patient 1 received from his prior physician. It is unclear how Respondent arrived at the starting dose of 4 mg three times a day. Respondent's notes for the patient do not reveal the duration of each session. In the "mental status" section, the notes fail to mention potential suicide or homicide risks.

E. By failing to record a pill count or if the patient had a left-over supply of buprenorphine. Overdosing is common in opioid users. Because of the risk of overdosing and diversion, it is significant that there is no pill count documented. Keeping an accurate and frequent pill count is part of the treatment of opioid use.

F. During an interview with an investigator for the Board, Respondent speculated that Patient 1 was "abusing" medications. However, he failed to document in the clinical record that he was taking precautions to rule that out in order to prevent any suspected abuse. Documenting a pill count, urine toxicology screening results, and periodic review of CURES reports would have addressed any issue of suspected abuse. Although Respondent relied on the negative drug screen from the prior treating physician from almost a month earlier, Respondent never dated and initialed when he reviewed the lab report. It is also unknown if or when he looked at any of the prior physician's medical records for Patient 1.

G. Respondent committed an extreme departure from the standard of care by prescribing Subutex instead of Suboxone, which is safer. Because Subutex does not contain naloxone, while Suboxone contains both buprenorphine and naloxone, Subutex is considered more dangerous. Subutex can be injected intravenously and abused. The addition of the opioid blocker naloxone to a partial opioid agonist, buprenorphine, prevents Suboxone from producing a high when inappropriately injected. When Suboxone is taken as prescribed, by mouth, naloxone is not absorbed and does not prevent Suboxone from being effective as an opioid blocker.

H. Respondent prescribed the more dangerous Subutex rather than safer Suboxone even though he believed, without proof, that Patient 1 was abusing buprenorphine. The standard of care in opioid abuse treatment is to use Suboxone, not Subutex. Occasionally Subutex is prescribed to a pregnant woman (to decrease the risk of exposure of the fetus to naloxone) or to individuals allergic to naloxone. Respondent did not prescribe or offer Suboxone to Patient 1. There was no discussion noted in the patient's medical records why Respondent prescribed Subutex in lieu of Suboxone. Since Respondent believed Patient 1 was abusing Subutex, he should have switched Patient 1 to Suboxone.

17. Respondent's acts and/or omissions as set forth in Paragraphs 11 through 16, inclusive above, whether proven individually, jointly, or in any combination thereof, constitutes gross negligence under Code section 2234, subdivision (b). Therefore, cause for discipline exists.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), and Health and Safety Code section 11165.4, subdivision (a), in that he committed repeated negligent acts with respect to his care and treatment of Patient 1. The circumstances are as follows:

19. The facts and allegations as set forth in Paragraphs 11 through 16, above, are incorporated by reference and re-alleged as if fully set forth herein.

20. Respondent's acts and/or omissions as set forth in Paragraphs 11 through 16, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts under Code section 2234, subdivision (c). Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

21. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that he demonstrated a lack of knowledge in his care and treatment of Patient 1. The circumstances are as follows:

22. The facts and allegations as set forth in Paragraphs 11 through 16, above, are incorporated by reference and re-alleged as if fully set forth herein.

23. During his treatment of Patient 1, Respondent demonstrated a lack of knowledge as to the safe, current medical standards currently employed by addiction specialists for the treatment of opioid use disorder.

24. Respondent's acts and/or omissions as set forth in Paragraphs 11 through 16, and 23, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute incompetence under Code section 2234, subdivision (d). Therefore, cause for discipline exists.

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FOURTH CAUSE FOR DISCIPLINE

(Inadequate Recordkeeping)

25. Respondent is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate records with respect to the care and treatment that he provided to Patient 1. The circumstances are as follows:

26. The facts and allegations as set forth in Paragraphs 11 through 16, above, are incorporated by reference and re-alleged as if fully set forth herein.

27. Respondent's acts and/or omissions as set forth in Paragraphs 11 through 16, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate recordkeeping under Code section 2266. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

28. Respondent is subject to disciplinary action under section 2234 and Health and Safety Code section 11165.4, subdivision (a), in that he engaged in unprofessional conduct with respect to his care and treatment of Patient 1. The circumstances are as follows:

29. The facts and allegations as set forth in Paragraphs 10 through 27, above, are incorporated by reference and re-alleged as if fully set forth herein.

30. Respondent's acts and/or omissions as set forth in Paragraphs 10 through 27, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct under Code section 2234. Therefore, cause for discipline exists.

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that, on February 21, 2020, in a prior disciplinary matter entitled *In the Matter of the First Amended Accusation Against Prakashchandra Patel, M.D.*, Case No. 800-2016-020370, Respondent was publicly reprimanded in connection with his violations of the Medical Practice Act, as set forth in First Amended Accusation No. 800-2016-020370, as follows: "In or about 2012 through 2017, Dr. Patel failed to adequately follow up on the prior

treatment received by three of his patients, who were also under the care of their primary care physicians."

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 A 32995, issued to Respondent Prakashchandra Chhotabhai Patel, M.D.;

2. Revoking, suspending or denying approval of Prakashchandra Chhotabhai Patel, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Prakashchandra Chhotabhai Patel, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 20 2021

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

Complainant

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