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

In the Matter of the Accusation Against: **FRANCISCO S. PARDO, M.D.** **2140 Hayden Way** **San Diego, CA 92110** **Physician's and Surgeon's Certificate No. G 57474,** Respondent.	Case No. 800-2020-067064 **A C C U S A T I O N**

PARTIES

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

2. On or about June 16, 1986, the Medical Board issued Physician's and Surgeon's Certificate No. G 57474 to Francisco S. Pardo, 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 February 29, 2024, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California, Department of Consumer Affairs, 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 states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

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

". . .

"(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.

". . . ."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and

shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. 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."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

COST RECOVERY

9. 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 DRUGS

10. **Adderall**, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system (CNS) stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder (ADHD) and narcolepsy. According to the Drug

Enforcement Administration (DEA), amphetamines, such as Adderall, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2017), at p. 50.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

11. **Atripla** is a fixed-dose combination medication (efavirenz, emtricitabine and tenofovir) indicated in the treatment of the human-immunodeficiency-virus-1 (HIV-1) infection in adults. Atripla can cause serious, life-threatening side effects, including buildup of lactic acid in the blood, liver problems, severe skin rash and allergic reactions, mental health problems, and new or worsening kidney problems, including kidney failure.

12. **Diazepam**, known by the trade name Valium, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces CNS depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance. The DEA has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

13. **Fentanyl** (Actiq, Fentora, Subsys, and Duragesic) is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication ordinarily used to treat patients with severe pain, especially after surgery. When properly prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant patients, severe enough to require daily, continuous, long term opioid treatment, and for which alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Code section 4022. The Food and Drug Administration (FDA) has issued several black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and

misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants. Fentanyl comes in several forms, including as an injection, spray (Subsys), intrathecal administration (an injection around the spinal canal), a transdermal patch that is placed on the skin, or as a lozenge that is sucked like a cough drop (Actiq).

14. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen and is a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Code section 4022. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, hydrocodone is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence, there is also the risk of acute liver failure which has resulted in a black box warning being issued by the FDA. The DEA has identified opioids, such as hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.)

15. **Hydromorphone** (Dilaudid), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The DEA has identified hydromorphone, such as Dilaudid, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The FDA has issued black box warnings for Dilaudid which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid with benzodiazepines or other CNS depressants.

16. **Oxycodone with acetaminophen** (Percocet), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is

used for the management of moderate to moderately severe pain. The DEA has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The FDA has issued a black box warning for Percocet which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

17. **Oxycodone HCL** (OxyContin) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, OxyContin is used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. The DEA has identified OxyContin as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

18. **Soma** (carisoprodol) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country.

19. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

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20. **Zolpidem**, known by the trade name Ambien, is a Schedule IV controlled substance, and a sedative primarily used to treat insomnia. It is a dangerous drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is a CNS depressant and should be used cautiously in combination with other central nervous system depressants. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject 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 S, H, A, W, C and G, as more particularly alleged hereinafter:

PATIENT S

22. Respondent began treating Patient S,[1] a then 42-year-old male, on or about March 3, 2017. Patient S presented with a number of comorbidities, including ADHD (attention deficit/hyperactivity disorder), hypotension, lower back pain, hip pain, wrist pain, migraines, depression, bipolar II disorder, and cocaine abuse. Patient S's last visit with Respondent occurred on or about July 7, 2022.

23. At the first visit, Respondent noted that a controlled substance agreement (CSA) was signed, however, absent from the patient records were key elements of the CSA, such as adherence to scheduled appointments, not to use illicit drugs, submit to urine drug screenings (UDS), the benefits, risks and alternatives of the medication(s), adherence to a single pharmacy, and that the agreement was understood and voluntary.

24. Respondent started Patient S on regular prescriptions for oxycodone (150 mg daily) and Soma (1050 mg daily). The following month, Respondent began regular prescriptions for Adderall (60 mg daily). On or about June 20, 2017, Respondent noted that the psychiatric

[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

emergency team had been called a number of times, and that "coercing him into a 5150 hold" had been unsuccessful. Respondent indicated that a number of pharmacies would no longer fill the patient's prescriptions, and that he was a high risk of hurting himself and had many connections to "on the street opiate sources." It was noted that if Respondent could not monitor the patient, a referral to drug enforcement for diversion may be needed, and that "extra caution and strict approach" must be applied.

25. On or about June 27, 2017, Respondent started regular prescriptions for oxymorphone (30 mg daily), however, Respondent did not note that oxymorphone was being introduced. Respondent did not issue Patient S any opiate prescriptions between January 2018 and September 2018, at which time he resumed regular prescriptions for oxycodone, Adderall, and Soma, and oxymorphone the following month. On or about September 25, 2018, Respondent noted that he reestablished patient care from Europe, but did not note the patient's medical care in Europe or whether opiate prescriptions were adjusted.

26. On or about November 15, 2018, Patient S underwent a UDS, which did not detect the presence of any of the controlled substances being prescribed by Respondent, including a prescription for 180 pills of oxycodone filled just one week prior. Two weeks later, Patient S tested positive for heroin, methamphetamine, amphetamine, and alprazolam. Again, he tested negative for his regularly prescribed medications, oxycodone and oxymorphone.

27. On or about December 26, 2018, Respondent discussed the positive heroin/methamphetamine test with Patient S, however, the patient denied illicit drug use and claimed the positive tests were the result of taking Sudafed and eating "poppy seed bagels and muffins." Respondent noted the pain contract was discussed, stating "3 strikes and you're out." The results of the November 15, 2018, UDS were not addressed by Respondent despite Patient S being at an elevated risk for opiate-related aberrant behavior, including diversion.

28. On or about March 26, 2019, Respondent noted that Patient S had presented to the ER multiple times and had not come into the office for one month, even though the opioid contract required that the patient be seen every two weeks, including conducting a UDS every two weeks. On or about October 31, 2019, Respondent noted opioid dependence. On or about May 10, 2020,

Respondent noted that Patient S had a "potential opiate overdose" and it was unlikely that the patient would ever be in complete remission of addiction. On or about December 30, 2019, Patient S came to Respondent's residence unannounced at 11:00 p.m., and told Respondent that he was in unbearable pain and did not want to live that way. Respondent dismissed calling a psychiatric emergency team or sending the patient to the ER, and instead "de-escalated" the situation over the course of 3.5 hours.

29. On or about February 14, 2020, Respondent noted that Patient S had previously tested positive for cocaine, and had been incarcerated for a "drug charge." On or about December 8, 2020, Respondent noted another negative UDS test for prescribed medications, and highlighted that Patient S had an "unacceptable high number of negative toxicology visits, requiring extra monitoring"

30. On or about January 19, 2021, another patient of Respondent's reported that Patient S had sold two oxycodone pills for pain. Respondent noted just 10 days later that Patient S was missing his bi-monthly UDS, and that a welfare check at his home was recently conducted in order to confirm there was no "increased" suicide ideation. On or about February 12, 2021, Respondent noted that the morphine milligram equivalents (MME) would be reduced due to Patient S's "suicide ideation with plan," and that Patient S would be entering drug rehabilitation. On or about June 7, 2021, Patient S tested positive for methamphetamine and fentanyl. Respondent noted that if Patient S would remain in the practice, he would need to enter drug rehabilitation.

31. Rather than decreasing the average MME dose for Patient S throughout the course of treatment, Respondent increased the average MME each year that Patient S was under his care. In 2017, the average daily MME was approximately 461. In 2018, once opiate prescriptions were resumed in September, the average MME was approximately 492. In 2019, the average daily MME increased to approximately 718. In 2020, the average daily MME again increased to approximately 756. In approximately January 2021, the average daily MME was a staggering 1350. On numerous occasions, Respondent issued multiple prescriptions for oxycodone that were filled on the same date. For example, in approximately March 2019, Respondent prescribed 600

pills of oxycodone (30 mg), while at the same time prescribing another opiate, oxymorphone, as well as Soma and Adderall.

32. At no time did Respondent check CURES[2] prior to or periodically while prescribing controlled substances to Patient S, even though the patient was known to be at an elevated risk for aberrant drug behavior. Finally, Respondent performed invasive procedures (injections) on Patient S 25 times, yet failed to document necessary elements, including signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions to the patient on 11 of 25 occasions, and informed consent was absent on over 50% of the procedures.

33. Respondent committed gross negligence in his care and treatment of Patient S which included, but was not limited to, the following:

(a) Respondent failed to establish the presence of an appropriate CSA and/or enforcement of the CSA after Patient S repeatedly failed to adhere to it;

(b) Respondent inappropriately prescribed and continued opiates without proper periodic assessments of safe opiate use and/or deescalate opioid use to the lowest effective dosage;

(c) Respondent failed to properly review and document CURES; and

(d) Respondent failed to properly document invasive procedures.

PATIENT H

34. Respondent started treating Patient H, a then 69-year-old male, on or about February 27, 2018. Patient H had a history of hypertension, diabetes, chronic neck and back pain, and cocaine use. Respondent issued a prescription for Percocet on or about February 23, 2018, four days prior to the initial visit. While a CSA was noted at the first visit, it was not signed by the patient until five months later on or about July 30, 2018. Regular prescriptions of Percocet (50 mg oxycodone daily) would continue, while regular prescriptions for Soma (1050 mg daily)

[2] The Controlled Substance Utilization Review and Evaluation System (CURES) is a platform that tracks all Schedule II – IV controlled substances dispensed to patients in California.

started in approximately April 2018. Respondent Patient H was under the care of Respondent until approximately July 2022.

35. Patient H tested positive for cocaine during a routine UDS on or about September 20, 2018. The patient claimed that it was a false positive due to taking amoxicillin for strep throat. Approximately, two months later, Patient H again tested positive for cocaine on or about December 27, 2018. Less than two months later, Patient H had a third positive UDS for cocaine.

36. It was not until on or about March 28, 2019, that Respondent confronted Patient H with the previous two positive cocaine tests, and noted, "three strikes, and you're out." Respondent indicated that the patient was aware that the UDS must be negative before medications would be filled again. However, prescriptions for Percocet would be filled on multiple occasions before the next UDS was performed on or about June 2, 2019. On or about August 29, 2019, Patient H against tested positive for cocaine. On or about September 24, 2019, Respondent noted that he discussed the most recent positive cocaine test and again indicated, "three strikes, and you're out." On or about October 1, 2019, Patient H tested positive for cocaine once again, yet Respondent continued numerous prescriptions for controlled substances.

37. On or about October 1, 2019, Patient H against tested positive for cocaine. At the office visit on or about October 11, 2019, Patient H denied cocaine use and Respondent discussed the three strikes rule with him again (even though this would be the fifth strike). On or about December 31, 2019, Respondent noted, "there will be no further second chances with respect to violation of the opiate contract." On or about January 10, 2020, Patient H admitted to cocaine use as he believed it helped his pain, yet Respondent continued to issue more prescriptions for opiates. On or about February 13, 2020, Respondent noted a "slip up" Patient H had when he used THC last month. In total, lab toxicology testing was performed on seven occasions between approximately September 2018 and October 2019, and Patient H tested positive for cocaine six times. Further, Respondent issued approximately 17 prescriptions for Percocet and 16 prescriptions for Soma following the March 2017 "three strikes" breech discussion.

38. On or about August 2, 2019, Respondent documented, "diabetic foot ulcer, 6/10, upward trend." There lacked any notes regarding the pertinent circumstances related to the

diabetic foot ulcer, including whether it was worsening, vascular integrity, whether it was wet/dry gangrene, or whether there existed the potential for necrotizing fasciitis[3] if gas gangrene was present. Similarly, there was no relevant documentation regarding the initial management, treatment, referral to a specialist (podiatrist), or need for urgent or emergent care.[4] Under assessment, Respondent indicated Percocet, which is insufficient treatment for a stage 4 foot ulcer. Patient H was already at risk for ischemic peripheral artery disease[5] given his history. Patient H was seen two weeks later, however, there was no mention of the left ankle foot ulcer or gangrene, and no examination of the feet was conducted.

39. Respondent performed invasive procedures (injections) on Patient H on 21 occasions, yet failed to document necessary key elements of the procedure, including informed consent, signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions, on 15 of 21 occasions. On one occasion on or about July 29, 2022, Respondent documented an injection was performed in the office even though it was a telemedicine visit while the patient was in North Carolina.

40. Respondent commonly failed to document relevant circumstances regarding Patient H's pain, including location, duration, alleviating, triggering, and aggravating factors, as well as associated physical findings. For example, at the initial visit on or about February 27, 2018, Respondent noted that the chief complaint was lumbosacral pain, 6/10 intensity, and the course was stable. However, a SLR test[6] was not conducted, nor were deep tendon reflexes or other details surrounding the circumstances of the patient's pain documented. Respondent also noted neck pain, but did not document the circumstances or a neck examination.

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[3] Necrotizing fasciitis is rare bacterial infection that spreads quickly in the body and can cause death.

[4] The complications associated with untreated stage 4 foot ulcer and/or gas gangrene are severe, irreversible, limb and life-threatening.

[5] Peripheral artery disease is a common condition in which narrowed arteries reduce blood flow to the arms or legs.

[6] The straight leg raise (SLR) test is regularly used to identify disc pathology or nerve root irritation as it mechanically stresses the lumbosacral nerve roots.

41. At no time did Respondent check CURES prior to or periodically while prescribing controlled substances to Patient H, even though he was known to be at an elevated risk for aberrant drug behavior. While Respondent did not prescribe excessive doses of opiates to Patient H, he failed to appropriately titrate the dose, consider alternative medications at the lowest effective dose, or document the initial circumstances and proper examination of the patient's reported pain.

42. Respondent committed gross negligence in his care and treatment of Patient H which included, but was not limited to, the following:

(a) Respondent failed to enforcement the CSA after Patient H repeatedly failed to adhere to it and Respondent acknowledged the breeches;

(b) Respondent failed to properly diagnose, treat, refer to a specialist, and document the patient's diabetic foot ulcer;

(c) Respondent inappropriately initiated and continued opiates without titration or considering effective alternatives;

(d) Respondent failed to properly review and document CURES;

(e) Respondent failed to properly document invasive procedures; and

(f) Respondent failed to document the relevant circumstances regarding the patient's reported pain and the related physical findings.

PATIENT A

43. Respondent began treatment with Patient A, a then 72-year-old female, on or about October 7, 2016. Patient A presented with a history of depression, anxiety, bipolar II disorder, hypertension, back pain, neck pain, lumbosacral spondylosis with radiculopathy, chronic L1 compression fracture, chronic obstructive pulmonary disease (COPD), Ehlers-Danlos syndrome,[7] diabetes mellitus,[8] and opioid dependence. She had reportedly been prescribed controlled

[7] Ehlers-Danlos syndrome, also known as EDS or elastic skin, is group of inherited disorders that mostly affect the skin, joints, and blood vessels. There lacked any laboratory data in the patient's records to support the diagnosis of EDS.

[8] There lacked any laboratory data in the patient's records to support the diagnosis of diabetes mellitus. There was no mention of "diabetic foot," which could be indicative of diabetes mellitus.

substances for three decades by prior physicians. Respondent began issuing regular prescriptions for hydromorphone (12 mg daily), OxyContin (120 mg daily) and Ambien (10 mg daily).

44. On or about July 31, 2017, September 12, 2017, November 10, 2017, and November 21, 2018, Patient A had the following significantly high blood pressure readings: 216/95, 211/81, 212/94, and 214/98, respectively. On each occasion, Respondent failed to document whether a cerebrovascular or cardiovascular examination was conducted to determine whether Patient A had potentially compromised organs, and whether Patient A was experiencing hypotensive emergency versus hypotensive urgency.[9] Further, on each visit, there was no documentation indicating that the blood pressure was rechecked, whether anti-hypertensive medications were reinstituted or intensified, or whether there was prompt follow-up (other than in four weeks). On only one occasion (July 31, 2017) was Patient A told by Respondent to go to the emergency room and take an anti-hypertensive medication. However, there was no closely monitored follow-up appointment to determine the response to the medication or a repeat blood pressure reading following the medication. Lastly, Respondent failed to document the relevant circumstances leading up to the elevated blood pressure readings, including food, caffeine, and/or medication consumption.

45. On or about February 22, 2017, January 29, 2019, July 9, 2019, and August 13, 2019, Patient A had the following abnormally high respiratory rate readings: 40, 29, 29, and 30, respectively. Even though the patient had a tachypneic respiratory rate (rapid, shallow breathing) on these visits, Respondent noted Patient A's respiratory rate was normal on the first two occasions, while noting that no respiratory examination was performed on the latter two occasions.

46. At no time did Respondent check CURES prior to or periodically while prescribing controlled substances to Patient A. Additionally, Respondent performed invasive procedures (injections) on Patient A on 11 occasions, yet failed to document necessary key elements of the

[9] Hypotensive urgency occurs when a blood pressure reading is 180 systolic or higher, or 120 diastolic or higher, but there are no signs of organ failure; whereas, a hypotensive emergency occurs under the same blood pressure readings, but there are signs of life-threatening damage to the body's organs. Clinically stable patients with hypertensive urgency can be safely sent home with anti-hypertensive medication and a follow-up visit within 24 hours.

procedure, including informed consent, signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions, on 9 of 11 occasions. Additionally, there were three occasions that Respondent noted the procedures were done at the patient's home, one of which indicated an ultrasound was used without any associated documentation.

47. Patient A's last visit with Respondent occurred on or about November 24, 2021, while she was hospitalized with a stroke. Patient A had been admitted to the hospital one week earlier with worsened renal failure, hypotensive, anemic, bilateral hematoma, and non-occlusive left thrombus. Patient A passed away on or about December 5, 2021. The cause of death was unrelated to the controlled substances being prescribed.

48. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to properly review and document CURES;

(b) Respondent failed to appropriately assess the patient to determine whether each hypotensive crisis was emergency or urgency, document the relevant circumstances, and treat accordingly;

(c) Respondent failed to properly assess and document the symptoms, physical examination, and treatment plan of the patient exhibiting significantly abnormal respiratory rates; and

(d) Respondent failed to properly document invasive procedures.

PATIENT W

49. Respondent started treating Patient W, a then 58-year-old female, on or about April 23, 2018. Patient W had a history of hypertension, bipolar I disorder with narcissistic personality disorder, chronic lower back pain, and bilateral shoulder pain. Respondent started issuing regular prescriptions for hydromorphone (24 mg daily), fentanyl transdermal (100 mcg), and Xanax (2 mg daily) on or about April 9, 2018, two weeks prior to the first visit. Regular prescriptions for Soma (1050 mg daily) started on or about January 4, 2019, while OxyContin (75 mg daily) began approximately two months later. Respondent continued Patient W on the aforementioned controlled substances until at least February 2023, with the exception of hydromorphone

(discontinued in approximately February 2020), and Soma (discontinued in approximately November 2021).

50. Respondent maintained Patient W on high average MME doses each year that she was under his care. In 2018, the average daily MME was approximately 214. In 2019, the average MME increased to approximately 226. In 2020, the average daily MME was approximately 212. In 2021, the average daily MME was approximately 196. Despite the patient being at moderate risk for aberrant drug risk, UDS was only performed on two occasions, while on two additional occasions, UDS is mentioned, but the tests are not included in the records.

51. On or about November 27, 2018, February 7, 2019,[10] March 5, 2019, and January 20, 2022,[11] Patient W had the following significantly irregular blood pressure readings: 209/112, 164/134, and 187/109, respectively. On each occasion, there lacked any documentation whether a cerebrovascular or cardiovascular examination was conducted to determine whether Patient W had potentially compromised organs, and whether she was experiencing hypotensive emergency versus hypotensive urgency. There also lacked documentation indicating that the blood pressure was rechecked, nor were prompt follow-up visits scheduled within 24 hours; instead, the patient was not seen until several weeks later on each occurrence. On the first two occasions, Patient W reported her lumbosacral pain as 8/10 and 7/10, respectively, which may have explained the high blood pressure, yet an appropriate physical examination was not performed.[12] Further, while pain intensity may increase blood pressure, there was no clear correlation between the two in any visit. Lastly, Respondent failed to document the relevant circumstances leading up to the elevated blood pressure readings, including food, caffeine, and/or medication consumption.

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[10] On February 7, 2019, there was no documentation when the patient had last taken her high blood pressure medication, nor was it filled at that time.

[11] On January 20, 2020, the reason for the visit was "hypertension," yet Respondent failed to mention the significantly high blood pressure or provide a treatment plan.

[12] Had the bilateral lower extremities sensory-motor deficits reflected a dissecting aortic aneurism, this would be considered a hypertensive emergency.

52. On or about June 30, 2021, Patient W had a telemedicine visit, where her blood pressure measure at 184/92. Respondent did not request that the patient come in to the office to have her blood pressure rechecked, and the next visit was not until over three weeks later. The reason for the telemedicine visit was a possible hand fracture, yet Respondent failed to note a visual examination or treatment plan.

53. On or about September 4, 2018, the patient presented with possible deep vein thrombosis (DVT).[13] However, there lacked documentation regarding which extremity was possibly affected, how long the patient was having symptoms, precipitating factors, or whether a physical examination was conducted. Respondent was also aware that the patient was on medication that increased the risk for venous thromboembolism. At the next visit nearly two months later, there was no mention or follow-up regarding DVT. In a subsequent interview, Respondent indicated that he was aware that DVT was serious condition but he "did not have a high enough suspicion to have ordered a sonogram."

54. On or about September 13, 2019, Patient W saw Respondent for possible edema (excess swelling) of the hands and feet. However, Respondent did not document the symptoms, a relevant physical examination, or whether edema was actually present. Respondent later indicated in an interview that he was not really impressed with the edema, so did not feel the need to work it up. Further, he was unsure whether it was worse in the hands or feet.[14]

55. Respondent documented on only a single occasion on or about December 20, 2018, that he checked CURES, well after prescriptions for controlled substances began. Additionally, Respondent performed invasive procedures (injections) on Patient W on 15 occasions, yet failed to document necessary key elements of the procedure, including informed consent, pre, peri, and post-procedural events, and post-procedure instructions, on 12 of 15 occasions. Additionally,

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[13] Deep vein thrombosis occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs. DVT can lead to potentially life-threating complications.

[14] The presence of edema on all four extremities may be a sign of many serious medical conditions, including decompensated heart failure, portal hypertension, pulmonary hypertension, hypothyroidism with myxedema, and renal failure.

there were three occasions that Respondent noted the procedures were done at the patient's home, one of which indicated an ultrasound was used without any associated documentation.

56. Respondent committed gross negligence in his care and treatment of Patient W which included, but was not limited to, the following:

(a) Respondent failed to appropriately assess the patient to determine whether each hypotensive crisis was emergency or urgency, document the relevant circumstances, and treat accordingly;

(b) Respondent failed to appropriately assess and document the patient's medical concerns related to potential deep vein thrombosis;

(c) Respondent failed to appropriately assess and document the patient's medical concerns related to potential edema; and

(d) Respondent failed to properly document invasive procedures.

PATIENT C

57. Respondent started treating Patient C, a then 52-year-old male, on or about January 4, 2016.[15] Patient C presented with a number of comorbidities, including COPD, opioid dependence, depression, anxiety, seizures, HIV, lumbosacral pain, history of bone cancer, and cervicalgia. Patient C's addiction severity index was determined to be moderate to high. On or about February 1, 2016, Respondent started the patient on regular prescriptions for OxyContin (60-90 mg daily), and Percocet (975-1300 mg daily). In approximately January 2017, Respondent began the patient on Soma (700 mg daily).

58. In approximately April 2017, Respondent started issuing regular prescriptions for a fentanyl spray, Subsys[16] (1600 mcg daily). It was noted the reason Subsys was prescribed was due to a history of malignancy based on information received by a former provider, however, Respondent noted he did not see confirmatory studies of malignancies. At no time after did

[15] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[16] Subsys is indicated primarily for breakthrough pain associated with malignancy. In fact, Respondent noted in approximately June 2016 that he typically only prescribed Subsys in the hospital setting, and for hospice patients.

Respondent obtain the relevant medical records to verify whether Patient C had a known malignancy. Subsys would be prescribed 18 times over the next 21 months without reviewing a pathology report. On or about June 1, 2018, Respondent noted that Patient C must provide documented proof of the alleged cancer. Two weeks later, it was noted that Patient C completed chemotherapy and radiation for a "soft tissue neoplasm." Respondent continued to prescribe Subsys even though he believed that Patient C was obtaining fentanyl from the "street," and that the patient could have more appropriately obtained Subsys from his oncologist. In a subsequent interview, Respondent claimed that he never prescribed Subsys without a pathology report, even though there was no pathology report in the records. Additionally, Respondent stated that the malignancy was always in the "GI tract," even though there was no confirmatory pathology report.

59. On or about August 21, 2018, a CSA was signed by Patient C, which was approximately 30 months after regular prescriptions for opiates began. The CSA included language that the patient would not use any and illicit drugs. However, between September 2018 and February 2019, there were approximately six separate occurrences that Patient C's UDS was positive for methamphetamine. On one occasion, Patient C tested negative for two of his prescribed medication, Soma and OxyContin. Respondent noted that he believed the positive UDS for methamphetamine was a "false positive" on three occasions. Finally, on or about April 16, 2019, Respondent noted that he was giving Patient C "three chances" for positive UDS, but that the patient tested positive for methamphetamine and cocaine. It was also noted that Patient C was at a high risk for diversion and "we cannot allow this." No opiates were prescribed by Respondent to the patient thereafter.

60. On approximately 12 separate occasions between March 2016 and November 2018, Respondent prescribed two short acting opiates (either OxyContin, Percocet, or Subsys) at the same time or within one day of each other. At no time did Respondent check CURES prior to or periodically while prescribing controlled substances to Patient C, even though the patient was known to be at a high risk for aberrant drug behavior, including diversion, and was using multiple pharmacies. In fact, on or about December 12, 2017, Patient C was prescribed OxyContin by two

additional providers on the same day. Just two days later, Respondent issued the patient his regular prescription for OxyContin (in addition to Subsys and Soma). Patient C used three different pharmacies to fill each of the three prescription for OxyContin. On the patient's next office visit on or about December 29. 2017, there was no mention by Respondent that CURES was checked or that the patient was confronted. Between approximately November 13, 2017, to December 14, 2017, the patient's daily MME was at least 486, not including Subsys.

61. On or about June 13, 2017, Respondent began issuing Patient C a prescription for Atripla, a fixed-dose combination medication used for the treatment of HIV. However, Respondent never verified the patient had HIV prior to or while issuing this prescription, nor documented the need to prescribe this medication. Respondent, who is not an infectious disease specialist, was aware that Patient C was being seen at an HIV/AIDS clinic. Additionally, Respondent issued two prescriptions for Biktarvy, another prescription medicine used to treat HIV-1 in approximately February and June 2020. Respondent would continue issuing numerous prescriptions for Atripla until approximately July 2020, and without referring the patient back to the HIV/AIDS clinic for more appropriate specialty care. In a subsequent interview, Respondent stated that he started the patient on Atripla because he was concerned that the patient was previously on a nephrotoxic (damaging to the kidneys) HIV medication, even though a known side effect of Atripla is kidney damage and failure, and there was no lab report to suggest Patient C had impaired kidney function.

62. Respondent's documentation regarding Patient C was inaccurate or incomplete on multiple additional occasions. On or about May 16, 2016, Respondent noted a diagnosis of impacted cerumen (earwax blockage) and the patient had cerumen removed. However, there was no mention of the patient having symptoms associated with impacted cerumen or associated examination of the ear before and after the procedure. On or about December 29, 2017, Respondent noted Type 2 diabetes mellitus and diabetic foot, although a sensory exam was normal. There lacked any description of the "diabetic foot," other than noting "no edema." Cellulitis of the trunk was also noted, but there was no indication of a skin exam to suggest that the patient had cellulitis, nor was a plan of care documented.

63. Finally, Respondent performed invasive interventional procedures, including injections, on Patient C 16 times, yet failed to document necessary elements, including informed consent, pre, peri, and post-procedural events, and post-procedure instructions to the patient on 9 of 16 occasions. Patient C's last visit with Respondent occurred on or about December 1, 2022.

64. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Respondent inappropriately prescribed Subsys without obtaining or ordering confirmatory reports of malignancy, and/or while believing the patient was receiving fentayl from non-prescribed sources;

(b) Respondent failed to properly review and document CURES;

(c) Respondent inappropriately prescribed two-short acting opiates at approximately the same time on numerous occasions, and without documenting a clear reason for doing so;

(d) Respondent, a non-infectious disease specialist, inappropriately prescribed and continued HIV treatment medication, without verifying the patient had HIV, and while the patient was being treated at an HIV/AIDS clinic;

(e) Respondent failed to properly document invasive procedures; and

(f) Respondent's documentation was inaccurate and/or incomplete on numerous occasions.

PATIENT G

65. Respondent started treating Patient G, a then 39-year-old male, on or about June 27, 2016. The patient would be seen by Respondent for six years until approximately June 2022. Patient G had a history of neck and lumbosacral pain. Respondent began the patient on regular prescriptions for controlled substances one month prior to the first office visit, which included OxyContin (120-150 mg daily), Adderall (90 mg daily), Soma (700 mg daily), and Valium (30-35 mg daily). On or about July 31, 2018, a CSA was signed by Patient G, over two years after the initiation of opiate prescriptions.

66. On or about May 8, 2018, the sole toxicology test (dried blood spot) was collected for Patient G, which tested positive for heroin. On or about June 12, 2018, Respondent addressed the positive heroin test with the patient, who denied any illicit drug use. Respondent noted that the positive heroin test was likely a "false positive" due to Patient G eating "poppy seed bagels and muffins," and the patient had "always maintained a clean toxicology record as long as he's been in this practice."[17] Respondent also noted that an onsite toxicology test was performed at that visit and it was negative for heroin. However, there is no record of the onsite test and no subsequent toxicology tests were performed on Patient G when he was "off" poppy seed bagels and muffins. On or about September 25, 2018, Respondent noted that the "urine tox screen" was appropriate with no illicit medication. However, there is no record of a UDS being performed prior to this visit.

67. While there was evidence that Respondent had structured tapering of opiates over the course of treatment, there is no record for Respondent checking CURES prior to or periodically while prescribing controlled substances to Patient G. Additionally, Respondent performed invasive interventional procedures, including injections, on Patient G 10 times, yet documentation of the procedures were missing on four occasions, including informed consent, signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions. On half the occasions when documentation was present, Respondent failed to include implied consent for the invasive procedures.

68. Respondent committed gross negligence in his care and treatment of Patient G which included, but was not limited to, the following:

(a) Respondent failed to appropriately perform toxicology testing; and

(b) Respondent failed to properly document invasive procedures.

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[17] It is unclear what Respondent is referencing by the patient has always kept a "clean toxicology record" since there are no records evidencing any additional toxicology testing other than this sole occasion in six years.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

69. Respondent is further subject 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 S, H, A, W, C and G, as more particularly alleged herein.

PATIENT S

70. Respondent committed repeated negligent acts in his care and treatment of Patient S which included, but was not limited to, the following:

(a) Paragraphs 22 through 33, above, are hereby incorporated by reference and realleged as if fully set forth herein;

PATIENT H

71. Respondent committed repeated negligent acts in his care and treatment of Patient H which included, but was not limited to, the following:

(a) Paragraphs 34 through 42, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT A

72. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Paragraphs 43 through 48, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to accurately document the patient's medical conditions, including Ehlers-Danlos syndrome and diabetes mellitus.

PATIENT W

73. Respondent committed repeated negligent acts in his care and treatment of Patient W which included, but was not limited to, the following:

(a) Paragraphs 49 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to properly review and document CURES; and

(c) Respondent inappropriately prescribed and continued opiates without proper periodic assessments of safe opiate use and/or deescalate opioid use to the lowest effective dosage.

PATIENT C

74. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Paragraphs 57 through 64, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to establish the presence of an appropriate CSA and/or enforcement of the CSA after Patient C repeatedly failed to adhere to it;

PATIENT G

75. Respondent committed repeated negligent acts in his care and treatment of Patient G which included, but was not limited to, the following:

(a) Paragraphs 65 through 68, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to properly review and document CURES.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

76. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients S, H, A, W, C and G, as more particularly alleged in paragraphs 22 through 68, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

77. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive

prescribing of drugs or treatment to Patient S, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 22 through 33, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Lack of Knowledge)

78. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated a lack of knowledge regarding his documentation, diagnosis, treatment, and specialist referral pertaining to Patient H's diabetic foot ulcer, as more particularly alleged in paragraphs 34 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 57474, issued to Francisco S. Pardo, M.D.;

2. Revoking, suspending or denying approval of Francisco S. Pardo, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Francisco S. Pardo, 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;

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

DATED: APR 13 2023

JENNA JONES FOR
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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