13

13A

CONTROLLED SUBSTANCE REGISTRATION APPLICATION

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy, Suite 206 - Reno, NV 89521

Registration Fee: $80.00 (non-refundable money order or cashier's check only)
(This application cannot be used by PA's or APRN's)

(This is for reinstatement)

First: Kristin Middle: Adele Last: Hestdalen Degree: M.D.

SS#: _____ Date of Birth: _____

Practice Name (if any): Kristin Hestdalen, M.D.

Nevada Address: 5421 Kietzke Lane, Suite 101 Suite #: _____
*(will be new address)
(This must be a practicing address, we will not issue a license to a home address or to a PO Box only)

City: Reno State: NV Zip Code: 89511

E-mail: krishestdalenmd@gmail.com Contact E-mail: krishestdalenmd@gmail.com

Work Telephone: (775) 386 8125 cell # Fax: ~~(775)~~ TBA

TBA

Practitioner License Number: NV10215 Specialty: child + adolescent psychiatry

Sex: ☐ M or ☒ F

You must have a current Nevada license with your respective BOARD before we will process this application. The Nevada license must remain current to keep the controlled substance registration.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or Physical condition that would impair your ability to perform the essential functions of your license?....	☒	☐
1. Been charged, arrested or convicted of a ~~felony~~ or misdemeanor in any state?	☒	☐
2. Been the subject of a board citation or an administrative action whether completed or pending in any state? ...	☐	☒
3. Had your license subjected to any discipline for violation of pharmacy or drug laws in any state?.....	☐	☒

(see explanation)

If you marked **YES** to any of the numbered questions **(1-3)** above, include the following information & provide an explanation and documentation:

Board Administrative Action:	State	Date:	Case #:
		/ /	

Criminal Action:	State	Date:	Case #:	County	Court

It is a violation of Nevada law to falsify this application and sanctions will be imposed for misrepresentation. I hereby certify that I have read this application. I certify that all statements made are true and correct.

I understand that Nevada law requires a licensed physician who, in their professional or occupational capacity, comes to know or has reasonable cause to believe, a child has been abused/neglected, to report the abuse/neglect to an agency which provides child welfare services or to a local law enforcement agency.

[signature] 3/31/19

Original Signature, no copies or stamps accepted. Date

Board Use Only: Date Processed: _____ Amount: 80.00

Explanation for Affirmative Answer to Question #1 -CS Renewal Application

On November 21, 2018, I was involved in an automobile accident to which law enforcement responded. I was required to submit to a field sobriety test. I was arrested for driving under the influence after failing the nystagmus test. Subsequently I was found to have cocaine metabolite in my blood and was charged with a misdemeanor charge of driving under the influence and failure to reduce speed and exercise due care.* A copy of the Amended Criminal Complaint is attached. I am entering into a ninety day in-patient professionals program through Talbott Recovery on April 10, 2019 and the pending criminal matter will be continued until after my return from Talbott Recovery.

6/16/19

* Addendum: I am currently at Talbott Recovery and do not have the Amended Criminal Complaint with me. It basically says what the above explanation does – That I have been charged with a misdemeanor DUI and failure to use due care. The DUI is for having a positive nystagmus test and a cocaine metabolite in my blood test.

Kristin Hestdalen M.D.

Kristin Hestdalen, M.D.
5421 Kietzke Lane, Suite 101
Reno, Nevada. 89521

March 31, 2019

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy, Suite 206
Reno, NV 89521

To Whom It May Concern:

I am a board-certified child and adolescent psychiatrist licensed to practice medicine in the state of Nevada for 18 years. I was the victim of domestic violence in June, 2017. My ex-partner was finally convicted of domestic battery in June, 2018. I have been receiving treatment for a diagnosis of PTSD with a local psychiatrist and psychologist. During that time I was on the benzodiazepine, clonazepam, for sleep and anxiety. I was charged with a misdemeanor DUI on November 21, 2018, while on clonazepam, although, the roadside breathalyzer test was zero. The resolution of this is still pending. I voluntarily decided to get treatment for my anxiety and substance use at a residential treatment facility and completed the 30 day program on January, 2019. I continue to receive treatment on an outpatient basis.

In an abundance of caution and on the advice of my psychiatrist, I am going to a 90 day program at Talbott Recovery (physician track). Please contact me if you have any concerns or questions.

Sincerely,

K Hestdalen

Kristin A. Hestdalen, MD

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information	
Name:	Kristin Adele HESTDALEN
Address:	Sierra Mental Health Associates 691 Sierra Rose Drive, Suite B Reno NV 89511
Phone:	7758252503

License Information			
License Type:	Medical Doctor		
License Number:	10215	Status:	Active
Issue Date:	7/1/2002	Expiration Date:	6/30/2019

Scope of Practice

Scope of Practice: Child Psychiatry
Scope of Practice: Psychiatry

Education & Training

School:	Loma Linda University / Loma Linda, CA
Degree\Certificate:	Medical Doctor Degree
Date Enrolled:	
Date Graduated:	5/28/1995
Scope of Practice:	

School:	Oregon Health Sciences Univ / Portland, OR
Degree\Certificate:	Residency
Date Enrolled:	7/1/1995
Date Graduated:	6/30/1998
Scope of Practice:	Psychiatry

School:	Stanford University / Stanford, CA
Degree\Certificate:	Fellowship
Date Enrolled:	11/15/1998

Date Graduated:	11/15/2000
Scope of Practice:	Child Psychiatry

School:	Psychiatry and Neurology
Degree\Certificate:	American Board
Date Enrolled:	
Date Graduated:	1/7/2002
Scope of Practice:	Psychiatry

CURRENT EMPLOYMENT STATUS/CONDITIONS/RESTRICTIONS ON LICENSE AND MALPRACTICE INFORMATION

NONE

Board Actions

NONE

Please note that the settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee even though there is a closed malpractice claim on file. A payment in the settlement of medical malpractice does not create a presumption that medical malpractice occurred. Sometimes insurance companies settle a case without the knowledge and/or agreement of the physician. This database represents information from insurers to date. Please note: All insurers may not have submitted claim information to the Board.

Close Window

13B

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

CONTROLLED SUBSTANCE APPLICATION

Registration Fee: $80.00 (non-refundable money order only, no cash)

(This application can not be used by PA's or APRN's)

First: David Middle: James Last: Smith Degree: MD

Practice Name (if any): Neuropathy and Pain Centers of America

Nevada Address: 8084 W. Sahara Ave Ste B Suite #: B

(This must be a practicing address, we will not issue a license to a home address or to a PO Box only)

PO Box: Las Vegas, Nevada 89117 SS#:

E-mail address: SDRMSDDS@hotmail.com

City: Las Vegas State: NV Zip Code: 89117

Work Telephone: 702 257 7246 Date of Birth:

Fax: 702 586 2071 Sex: ☒ M or ☐ F

Practitioner License Number: 17853 Specialty: Interventional Pain

You must have a current Nevada license with your respective BOARD before we will process this application. The Nevada license must remain current to keep the controlled substance registration.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or Physical condition that would impair your ability to perform the essential functions of your license?...	☐	☒
1. Been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. Been the subject of a board citation or an administrative action whether completed or pending in any state?	☒	☐
3. Had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked **YES** to any of the numbered questions **(1-3)** above, include the following information & **provide an explanation and documentation**:

Board Administrative Action:	State		Case #:		
	CA	ACCUSATION	800-2015-013651		
Criminal Action:					

It is a violation of Nevada law to falsify this application and sanctions will be imposed for misrepresentation. I hereby certify that I have read this application. I certify that all statements made are true and correct.

I understand that Nevada law requires a licensed physician who, in their professional or occupational capacity, comes to know or has reasonable cause to believe, a child has been abused/neglected, to report the abuse/neglect to an agency which provides child welfare services or to a local law enforcement agency.

David J Smith 12/10/18

Original Signature, no copies or stamps accepted. Date

Board Use Only: : Date Processed: Amount: 80.00

103567

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information	
Name:	David James SMITH
Address:	3703 Camino Del Rio South Ste. 210 San Diego CA 92108
Phone:	6196405555

License Information			
License Type:	Medical Doctor		
License Number:	17853	Status:	Active
Issue Date:	4/16/2018	Expiration Date:	6/30/2019

Scope of Practice

Scope of Practice: Physical Medicine / Rehab

Education & Training

School:	Northwestern University SOM / Chicago, IL
Degree\Certificate:	Medical Doctor Degree
Date Enrolled:	
Date Graduated:	3/25/1988
Scope of Practice:	

School:	Univ of California VA Med Ctr / Los Angeles, CA
Degree\Certificate:	Internship
Date Enrolled:	6/24/1988
Date Graduated:	6/23/1989
Scope of Practice:	Internal Medicine

School:	Univ of California VA Med Ctr / Los Angeles, CA
Degree\Certificate:	Residency
Date Enrolled:	7/1/1989
Date Graduated:	6/30/1992
Scope of Practice:	Physical Med/Rehab

School:	Physical Med/Rehab
Degree\Certificate:	American Board
Date Enrolled:	
Date Graduated:	5/19/1993
Scope of Practice:	Physical Med/Rehab

School:	Physical Med/Rehab
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	7/1/2003
Scope of Practice:	Physical Med/Rehab

School:	Physical Med/Rehab
Degree\Certificate:	Am Bd Recertification
Date Enrolled:	
Date Graduated:	7/1/2013
Scope of Practice:	Physical Med/Rehab

CURRENT EMPLOYMENT STATUS/CONDITIONS/RESTRICTIONS ON LICENSE AND MALPRACTICE INFORMATION

NONE

Board Actions

NONE

Please note that the settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee even though there is a closed malpractice claim on file. A payment in the settlement of medical malpractice does not create a presumption that medical malpractice occurred. Sometimes insurance companies settle a case without the knowledge and/or agreement of the physician. This database represents information from insurers to date. Please note: All insurers may not have submitted claim information to the Board.

Close Window

EXPLANATION CONCERNING ACCUSATION
DAVID J. SMITH, M.D.

On April 27, 2018, the Medical Board of California ("MBC") filed an Accusation against my California license to practice medicine in connection with three patients. The allegations of the Accusation and my explanation of the care provided follow.

Patient L.T.

MBC Allegations. The MBC received a complaint that Patient L.T. died on April 19, 2015, of a drug overdose and the complaining party (the patient's ex-wife who is also a physician) believed that Dr. Smith prescribed too many pain medications. The case was reviewed by two experts on behalf of the MBC. *One expert opined that there were no departures from the standard of care.* So the MBC engaged another expert. That expert was critical of my office's chart notes which had some errors resulting from repopulation of data. Some notes were missing from five yeas ago because of a transition of EMR. The MBC provided an autopsy report that identified the patient's cause of death was "mixed medication intoxication (fentanyl, oxycodone, oxymorphone, and diazepam)".

My Response. I treated Patient L.T. over ten years in connection with chronic pain resulting from a back injury which occurred in his work as a firefighter. I offered the patient multimodal treatment, including referrals for surgery and depression. However, the patient was managed medically with medication.

I attempted to obtain help for this patient when he showed signs of abuse of his medications and, as a means of managing the risk he presented, transitioned him from his medications to a Butrans patch which has a safer side effect profile than other opioids. I discharged Patient L.T. after repeated violations of his opioid agreement, some of which were detected by the appropriate use of random, compliance laboratory testing.

With respect to the medications found in the patient at the time of his death, they were prescribed by physicians at the Veteran's Administration facility where he was being treated 16 months after his discharge from my care.

Patient B.H.

MBC Allegations. The MBC received a complaint from a hospitalist during the patient's in-patient admission for treatment of a condition unrelated to my care concerning management of Patient B.H.'s intrathecal pain pump. The Accusation filed by the MBC generally alleges that the concentrations of medication in the pain pump were excessive or that the pump was otherwise inappropriate managed.

My Response. I have been treating Patient B.H. for a number of years and she is supportive and grateful for my care. With her treatment, her function has improved with management of her chronic pain. She has had no adverse consequences of any kind from her treatment.

The MBC focus on the management of the patient's intrathecal pain pump is misplaced and based upon a lack of understanding of the application of intrathecal pain pumps for pain control. Apparently, both the complainant and the MBC are unaware that the Medtronic intrathecal pain pump used by me contained three medications used in combination to control Patient B.H.'s pain. The complainant attempted, without properly consulting me, to fill the patient's pain pump and he appears to have believed that because of his failure to consult me and to properly analyze the concentrations of medication in the patient's pump he may have improperly dosed the patient. The complaint should have either engaged me so that I could manage the patient's pump or should have at least spoken to me at length concerning the contents of the pump and how to properly fill it.

Patient M.K.

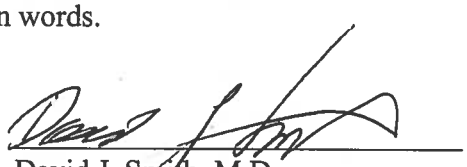
MBC Allegations. The MBC alleges that I prescribed excessive numbers of drugs, failed to document review of systems, failed to include a well-defined chief complaint, failed to accurately report information concerning prescribed medication, and failed to check CURES for patient drug compliance. The patient died from a drug overdose.

My Response. I began treating Patient M.K. in January of 2010 for consequences of a work injury and continued caring for her until 2012. During that time, I consistently checked CURES, as the the routine in my practice, and performed randomized drug tests. I am perplexed by the MBC allegations because they run counter to what is clearly documented in the patient chart and otherwise. A review of the CURES reports for the time in which I treated the patient show that she was only receiving controlled substances from me consistent with her opioid contract. The patient's complex history and chief complaints were amply noted in the chart patient.

Simultaneous with my care (largely because of the vocational nature of the injuries that caused her pain complaints), the patient was treated by a number of other physicians and healthcare professionals. Among others, the patient was evaluated by a psychologist and three orthopedic surgeons (including one who was her primary treating physician). The patient was also independently evaluated by another pain management physician as a part of an Agreed Medical Evaluation.

We attempted a number of non-prescription drug modalities to control the patient's use of opioids to control her pain. We attempted epidurals and considered a spinal cord stimulator. The patient was obese and I consistently recommended weight loss, including evaluation of weight loss surgery. Requests for intensive psychotherapy were denied by her insurer, although she did have some brief psychological care. During my care, the patient underwent a lumbar spine fusion.

I have read the foregoing narrative and agree that the contents of the "FACTS" section stated above are provided in my own words.

DATE: ___December 12, 2018_ 

David J. Smith, M.D.

MEDICAL BOARD OF CALIFORNIA

LICENSING DETAILS FOR: G 70778

NAME: SMITH, DAVID
LICENSE TYPE: PHYSICIAN AND SURGEON G
PRIMARY STATUS: LICENSE RENEWED & CURRENT
SECONDARY STATUS: MALPRACTICE JUDGMENT
SCHOOL NAME: UNIVERSITY OF CALIFORNIA, SAN DIEGO SCHOOL OF MEDICINE
GRADUATION YEAR: 1989
PREVIOUS NAMES: SMITH, DAVID
ADDRESS OF RECORD (REQUIRED)
1250 E ALMOND AVE
MADERA CA 93637-5606
MADERA COUNTY

ISSUANCE DATE
FEBRUARY 11, 1991
EXPIRATION DATE
JUNE 30, 2020
CURRENT DATE / TIME
APRIL 25, 2019
10:02:06 AM

PUBLIC RECORD ACTIONS

MALPRACTICE JUDGMENT (1)

- CITATION NUMBER: C952435SBA
- CAUSE: U.S. DISTRICT COURT, NORTHERN DIST. OF CALIF.
- JUDGMENT AMOUNT: 220000.00
- DATE ISSUED: AUGUST 27, 1997
- ADDITIONAL INFORMATION:

ADMINISTRATIVE DISCIPLINARY ACTIONS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
COURT ORDER (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
MISDEMEANOR CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
PROBATIONARY LICENSE (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
FELONY CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
HOSPITAL DISCIPLINARY ACTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
ISSUED WITH PUBLIC LETTER OF REPRIMAND (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
ADMINISTRATIVE CITATION ISSUED (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
ACTION TAKEN BY OTHER STATE/FEDERAL GOV (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
ARBITRATION AWARD (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
MALPRACTICE SETTLEMENTS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

PUBLIC DOCUMENTS

DOCUMENTS (NO RECORDS)

SURVEY INFORMATION

THE FOLLOWING INFORMATION IS SELF-REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE BOARD.

ARE YOU RETIRED?	NO
ACTIVITIES IN MEDICINE	PATIENT CARE - 40+ HOURS ADMINISTRATION - 40+ HOURS
PATIENT CARE PRACTICE LOCATION	ZIP - 95337 COUNTY - STANISLAUS
PATIENT CARE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
CURRENT TRAINING STATUS	NOT IN TRAINING
AREAS OF PRACTICE	EMERGENCY MEDICINE - SECONDARY
BOARD CERTIFICATIONS	NO BOARD CERTIFICATIONS IDENTIFIED
POSTGRADUATE TRAINING YEARS	3 YEARS
CULTURAL BACKGROUND	DECLINED TO DISCLOSE
FOREIGN LANGUAGE PROFICIENCY	DECLINED TO DISCLOSE
GENDER	MALE

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Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
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San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9417
Facsimile: (619) 645-2061

Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Feb. 13 20 19
BY [signature] ANALYST

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

In the Matter of the First Amended Accusation Against: **DAVID JAMES SMITH, M.D.** **3703 Camino Del Rio South, Suite 210** **San Diego, California 92108** **Physician's and Surgeon's License No. G66777,** Respondent.	Case No. 800-2015-013651 OAH No. 2018-080617 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about August 21, 1989, the Medical Board issued Physician's and Surgeon's Certificate No. G66777 to David James Smith, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on January 31, 2021, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board), 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 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, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

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

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

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(d) Incompetence.

" ..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or 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.).

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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 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."

9. 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.

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"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent has subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of patients A, B, C, and D,[1] as more particularly alleged hereinafter:

11. **Patient A**

(a) Since at least 2010, Patient A treated with Respondent for pain management due to chronic pain in her back, leg, knee, and shoulder.[2] In or around that time, Patient A already had an intrathecal pump[3] implanted. In or around 2012 and 2013, Respondent implanted multiple new intrathecal pumps in Patient A due to various medical issues.

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[1] Letters A, B, C, and D are used for the purposes of maintaining patient confidentiality.

[2] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient A is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] An intrathecal pump is a medical device used to deliver medication directly into the space between the spinal cord and the protective sheath surrounding the spinal cord for targeted drug delivery. An intrathecal pump delivers medicine directly into the Cerebrospinal fluid and requires a significantly smaller amount of medication compared to systemically taken (orally) medication due to bypassing the systemic path that oral medication must travel in the body. An intrathecal pump is programmable and it stores the information about medication in its memory. An intrathecal pump is programmed to slowly release medication over a period of time and can be programmed to release different amounts of medication at different times of the day. When the intrathecal pump's reservoir is empty, the medication is refilled by insertion of a needle through the skin and into the fill port on top of the pump's reservoir.

(b) From in or around 2011 to in or around 2017, Respondent managed Patient A's pain medication through intrathecal drug therapy and high dose systemic (oral) opioid drug therapy. During this same time frame, Respondent routinely filled Patient A's intrathecal pump with massive doses of controlled pain medication and routinely prescribed excessive doses of oral opioids and other controlled substances. Significantly, the potent and highly addictive medications from the combined drug therapies (intrathecal and systemic/oral) were being taken by Patient A at the same time, as prescribed by Respondent. In fact, Respondent, notwithstanding Patient A's intrathecal drug therapy, routinely prescribed excessive amounts of oral opioid medication that often exceeded well more than three hundred (300) morphine milligram equivalents (MME) in a day. Respondent prescribed these massive oral doses of opioids to Patient A on multiple dates including, but not limited to, October 2, 2017; July 25, 2016; September 4, 2013; and November 7, 2012.

(c) On or about October 2, 2012, Respondent replaced Patient A's existing intrathecal pump with a newer model.[4]

(d) On or about October 9, 2012, Respondent filled Patient A's newly installed pump with medication but failed to clearly and accurately document the concentration of initial medication that was used to fill the pump. According to the chart note for this outpatient visit, Respondent initiated the pump's medication with an extremely high amount of fentanyl.[5] Patient A's initiating fentanyl dose was documented at a concentration of 25 milligrams (mg) per milliliter (mL), with a

[4] A pump implant operative note indicated that Respondent implanted the Medtronic Synchromed II.

[5] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is a potent synthetic opioid drug used as an analgesic and anesthetic. Fentanyl is "approximately 100 times more potent than morphine and 50 times more potent than heroin as an analgesic." (Drugs of Abuse, Drug Enforcement Administration (DEA) Resource Guide (2017 Edition), at p. 40.)

starting dose of 2.499 mg of fentanyl per day. The chart note for this visit also documented filling the pump with Marcaine 5 mg/mL. The chart note further documented that Patient A was continuing to orally take Methadone[6] and Roxicodone[7] for pain. Respondent, notwithstanding the amount of controlled pain medications Patient A was getting through combined intrathecal and systemic drug therapies, also gave verbal orders for an intramuscular injection of Dilaudid[8] 4 mg for Patient A at this visit. Significantly, there was no observation period of Patient A following the pump's medication refill at this visit.

(e) Following a pump pocket fill of Patient A's intrathecal pump, Respondent sent her home after only one dose of Naloxone.[9] Significantly, Respondent failed to observe Patient A after this single dose and evaluate potential side-effects including, but not limited to, opioid over-dosage.

(f) In or around June 2015, Patient A was admitted for a prolonged admission to a hospital at the University of California San Diego (UCSD). During her admission, Patient A's intrathecal pump had to be filled with medication. A UCSD physician treating Patient A identified that the concentration of medication in her pump was "extremely high" and that the pump's internal computer listed the concentration of drugs in "milligrams," and not micrograms (mcg), even though mcg is the standard measurement of concentration of medication used in an intrathecal pump. Respondent personally verified the accuracy of the listed

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[6] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Roxicodone is a brand name for oxycodone, 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.

[8] Dilaudid is a brand name for hydromorphone, 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.

[9] Naloxone is a medication designed to rapidly reverse opioid overdose.

concentrations and infusion doses directly to the UCSD physician. A "formula sheet" containing a list of medication concentration was also faxed from Respondent's clinic to UCSD to again verify concentrations and dosages that the Respondent fills in Patient A's pump. The "formula sheet" clearly indicated that major discrepancies existed between its listed concentrations and dosages and the final concentrations actually contained in Patient A's pump.

(g) Respondent routinely issued prescriptions to Patient A for the concomitant use of addictive controlled pain medications including, but not limited to, MS Contin,[10] Roxicodone, benzodiazepines,[11] Soma,[12] and phentermine.[13] Prescriptions for this dangerous drug combination were issued to Patient A on multiple dates including, but not limited to, January 23, 2017; February 21, 2017; March 6, 2017; April 28, 2017; June 1, 2017; August 7, 2017; and October 2, 2017. Respondent failed to document his clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time he prescribed the concomitant use of these drugs to Patient A.

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[10] MS Contin is a brand name for morphine, 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.

[11] Benzodiazepines are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and are a dangerous drug pursuant to Business and Professions Code section 4022. Concomitant use of benzodiazepines with opioids may result in profound sedation, respiratory depression, coma, and/or death. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

[12] Soma is a brand name for carisoprodol, which 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. The DEA has identified Soma as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 27.)

[13] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. The DEA has identified phentermine as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

(h) From in or around 2011 to in or around 2017, Respondent, notwithstanding his knowledge of Patient A's documented history of drug and alcohol abuse and "drug seeking" behavior, continued to prescribe massive amounts of addictive controlled pain medication even after inconsistencies were discovered in her urine drug screens and Controlled Substance Utilization Review and Evaluation System[14] (CURES) reports indicating she had received controlled prescriptions from other physicians. The chart notes during this time frame fail to adequately document any discussion with Patient A about the reasons and/or explanations for these inconsistencies.

12. Respondent committed gross negligence in his care and treatment of patient A including, but not limited to, the following:

(a) Respondent, after initiation of intrathecal drug therapy, failed to reduce and/or eliminate Patient A's continued use of systemic opioid drug therapy;

(b) On or about October 9, 2012, Respondent initiated an excessive dose of fentanyl at an intended concentration of 25 mg/mL and a starting dose of 2.499 mg per day, in Patient A's intrathecal pump;

(c) On or about October 9, 2012, Respondent failed to initiate intrathecal therapy in an inpatient setting to observe whether Patient A had a safe response to the medication;

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[14] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

(d) On or about October 9, 2012, Respondent failed to initiate intrathecal therapy in an outpatient setting to observe whether Patient A had a safe response to the medication;

(e) On or about October 9, 2012, Respondent gave verbal orders for an intramuscular injection of Dilaudid 4 mg for Patient A despite the amount of controlled pain medications Patient A was already receiving through combined intrathecal drug therapy and systemic drug therapy;

(f) Respondent performed a pump pocket fill of Patient A's intrathecal pump, and, after administering a single dose of Naloxone, he failed to observe and evaluate the patient for potential side-effects of opioid over-dosage;

(g) Respondent failed to maintain adequate and accurate records by failing to accurately record information about medication used in Patient A's intrathecal pump, including, but not limited to, starting concentration of medication, final concentration of medication, starting and final concentration of medication after other medication was added, drug calculations, and other reported values of concentration and doses;

(h) Respondent failed to properly program medication information into Patient A's intrathecal pump, including, but not limited to, starting concentration of medication, final concentration of medication, starting and final concentration of medication after other medication was added; and other reported values of concentration and doses;

(i) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient A;

(j) Respondent routinely prescribed dangerous drug combinations and doses to Patient A including, but not limited to, MS Contin, Roxicodone, benzodiazepines, Soma, and phentermine;

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(k) Respondent failed to document his clinical judgment behind prescribing a controlled medication combination for concomitant use by Patient A with potentially lethal consequences; and

(l) Respondent, with knowledge of Patient A's documented drug seeking behavior, failed to provide appropriate treatment in that he, among other things, repeatedly prescribed excessive amounts of addictive pain medication to Patient A over an extended period of time, while failing to respond to objective signs of aberrant drug behavior.

13. **Patient B**

(a) Between in or around 2004 and in or around November 2013, Patient B treated with Respondent for pain management due to a number of medical issues including, degenerative disc disease and chronic low back pain.[15] On or about April 19, 2015, Patient B died of a drug overdose. The medical examiner's autopsy report determined his cause of death was from "mixed medication intoxication (fentanyl, oxycodone, oxymorphone, and diazepam)."

(b) Between in or around 2011 and in or around 2013, Respondent prescribed Patient B escalating doses of opioids in combination with other controlled drugs, including, but not limited to, benzodiazepines, antidepressants, muscle relaxants, and testosterone. In fact, Respondent prescribed excessive amounts of opioids including, but not limited to, on or about October 1, 2013, issuing a prescription for Roxicodone (30mg) (#140) amounting to approximately ten (10) tablets daily. Significantly, this prescription alone equaled an incredibly high four hundred fifty (450) MME.

(c) From in or around 2011 to in or around 2013, Respondent, notwithstanding his knowledge of Patient B's documented history of opioid

[15] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient B is for informational purposes only and is not alleged as a basis for disciplinary action.

dependence, alcohol and drug abuse, depression, and other aberrant drug behaviors, continued prescribing large amounts of addictive medication even after numerous inconsistencies were discovered in Patient B's urine drug screens and CURES reports, including, but not limited to, June 23, 2011 (inconsistent for Vicodin and Valium); March 14, 2013 (misused prescription); April 16, 2013 (misused prescription); and August 14, 2013 (+cocaine). The chart notes during this time frame fail to adequately document any discussion with Patient B about the reasons and/or explanations for these inconsistencies. Although Patient B's medications were discontinued on occasion due to non-compliance, the prescriptions were later continued with similar dosing strength and frequency. Significantly, Respondent failed to document any discussion with Patient B regarding a referral to addictionology or a rehabilitation facility despite multiple "red flags" involving drug abuse and depression.

(d) In a chart note dated November 29, 2012, it was documented that Patient B requested a different dosage of medication in order to help with his depression. At the next charted visit, on or about January 15, 2013, there is no documentation of a follow up on Patient B's request for a different dosage. However, it is documented that he has been experiencing increased anxiety but with no further comment or follow up charted in the note.

(e) There are missing chart notes for July, August, and September 2013. However, Patient B filled controlled prescriptions issued by Respondent during this time frame. In addition, there are chart notes documenting conflicting information regarding what medication was being prescribed and taken.

14. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent prescribed excessive amounts of opioids including, but not limited to, on or about October 1, 2013, issuing a prescription for Roxicodone (30mg) (#140) amounting to approximately ten (10) tablets daily;

(b) Respondent failed to effectively monitor and manage Patient B's drug use by continuing to prescribe addictive controlled medication after years of inconsistent drug tests, positive test result for cocaine, and/or repeated misuse of controlled prescriptions;

(c) Respondent failed to refer Patient B to addictionology or rehabilitation facility after repeated "red flags" of aberrant drug behavior;

(d) There are missing chart notes for July, August, and September 2013; and

(e) There are multiple inaccurate chart notes documenting conflicting information regarding what medication was being prescribed and taken.

15. **Patient C**

(a) Between in or around 2008 and in or around 2012, Patient C treated with Respondent for pain management due to chronic pain from a work related injury.[16] On or about July 22, 2012, Patient C died of a drug overdose. The medical examiner's autopsy report determined her cause of death was from "acute oxycodone, carisoprodol, and diazepam intoxication."

(b) Between in or around 2011 and in or around 2012, Respondent managed Patient C on many different medication classes for her drug therapy including, but not limited to, opioids (long acting and short acting), multiple benzodiazepines, neuropathic pain medication, multiple muscle relaxants at same time, and antiemetics. In fact, Respondent prescribed an excessive number of drugs that performed same or similar mechanisms of action to treat Patient C.

(c) Patient C's medical charts failed to include a review of systems, failed to consistently include a well-defined chief complaint, and failed to accurately record information regarding prescribed medication. In addition, there were no

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[16] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient C is for informational purposes only and is not alleged as a basis for disciplinary action.

CURES reports contained in Patient C's medical records nor any mention in her charts of checking CURES for patient compliance.

16. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent prescribed an excessive number of controlled drugs, including, but not limited to, opioids (long acting and short acting), benzodiazepines, muscle relaxers, and antiemetics to treat Patient C.

17. **Patient D**

(a) Between in or around December 2011, and in or around July 2012, Patient D treated with Respondent for pain management due to chronic pain.[17] On or about August 1, 2012, Patient D died of a drug overdose. The medical examiner's autopsy report determined her cause of death was from "acute tapentadol, fentanyl, and alprazolam intoxication."

(b) During the time that Patient D was under the care of Respondent, she was morbidly obese; she had a long history of poor pulmonary function and pulmonary disease; and she had a documented history of opioid dependence. Significantly, she had a long and documented history of multiple Emergency Department and hospital admissions for various medical conditions, including hospitalizations due to opioid induced respiratory depression.[18]

(c) On or about November 23, 2011, Patient D visited an Emergency Department and had requested a medication refill because her pain management doctor was "out of town." The medical record of that visit documented that Patient D's pain management doctor at the time, Dr. A.S., was contacted and that she had contradicted the patient's account regarding lack of medication.

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[17] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

[18] In 2011 and 2012, Patient D had multiple admissions to Emergency Departments and hospitals.

Furthermore, Dr. A.S. advised Emergency Department staff that she had been having difficulty with managing Patient D's pain due to the patient's "concomitant illicit drug use." Patient D was denied opioid medication from Emergency Department medical staff that day. Three days later, Patient D returned to the same Emergency Department and requested to be admitted for drug detoxification.

(d) On or about December 23, 2011, Respondent had his initial examination with Patient D. In the chart note for this visit, Respondent documented that "[Patient D] had leftover methadone from a *few years* ago and began taking due to the fact she was out of Oxy IR ... [Patient D] states she last took methadone this morning."

(e) Between in or around December 2011 and in or around July 2012, Respondent managed Patient D on many different medication classes for her drug therapy including, but not limited to, opioids, benzodiazepines, muscle relaxants, and anti-seizure medication at the same time.

(f) Significantly, Patient D's medical charts from Respondent's clinic do not contain any information about her vitals being taken at each clinical visit. In addition, the charts also do not include a review of systems and/or a well-defined chief complaint. Furthermore, the charts do not accurately record information regarding Patient D's past and then-currently prescribed controlled medication. Finally, Respondent prescribed Patient D large amounts of opioids without adequately documenting her past hospitalizations involving poor pulmonary function and pulmonary disease.

(g) In a chart note dated July 26, 2012, Respondent documented that Patient D had wanted to switch pain medications, namely, replace Dilaudid with Nucynta,[19] because she had reported that Nucynta was more effective for her pain

[19] Nucynta is a brand name for tapentadol, 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.

control. Respondent, notwithstanding Patient D's current dosages of the transdermal Fentanyl patch[20] along with other opioids, issued her a prescription for Nucynta (100mg) (#228).[21] The Nucynta prescription alone resulted in an increase of more than one hundred fifty (150) MME being taken by Patient D at that time.[22]

18. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to, the following:

(a) On or about July 26, 2012, Respondent prescribed an excessive amount of opioids when he issued Patient D a prescription for Nucynta (100mg) (#228); and

(b) Respondent failed to accurately record critical information in Patient D's medical record, including, but not limited to, failed to have vital signs taken and/or documented at each visit; failed to accurately record information regarding Patient D's past and then-currently prescribed controlled medication; and failed to document a review of systems and/or a well-defined chief complaint.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of patients A, B, C, D, and E,[23] as more particularly alleged hereinafter:

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[20] Transdermal fentanyl (Duragesic) patches are applied to the skin; used to relieve severe pain, the patch is usually applied to the skin once every 72 hours. Fentanyl patches may cause serious or life-threatening breathing problems. Taking certain medications (e.g., benzodiazepines and muscle relaxants) with fentanyl may increase the risk of serious or life-threatening breathing problems, sedation, or coma.

[21] Patient D's prescribed regimen of opioids represented a total of three hundred ninety-five (395) MME.

[22] Patient D had recently filled prescriptions for Dilaudid (Hydromorphone HCL) on July 10, 2012 (4mg) (#180), and on June 13, 2012 (4mg) (#180).

[23] Letter E is used for the purposes of maintaining patient confidentiality.

20. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

21. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

22. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) There are no CURES reports in Patient C's medical records nor any mention of checking CURES for patient compliance;

(c) In 2012, Respondent prescribed two (2) muscle relaxants at same time to Patient C; and

(d) Patient C's medical charts failed to include a review of systems; failed to consistently include a well-defined chief complaint; and failed to accurately record information regarding prescribed medication.

23. **Patient D**

(a) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Patient D's medical charts failed to include and/or document any information regarding Patient D's past multiple hospitalizations.

24. **Patient E**

(a) Between in or around April 2013, and in or around October 2013, Patient E treated with Respondent for pain management due to low back pain.[24] On or about December 15, 2013, Patient E died of a drug overdose. The medical

[24] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

examiner's autopsy report determined his cause of death was from "acute bronchopneumonia; contributing: chronic prescription medication abuse with acute oxycodone and alcohol intoxication; pulmonary emphysema; hepatic cirrhosis."

(b) Between in or around April 2013, and in or around October 2013, Respondent managed Patient E on high dosages of opioids and benzodiazepines at the same time.

(c) In a chart note dated June 26, 2013, it was documented that a prescription was issued to Patient E to obtain a urine drug screen (UDS). The results of the UDS later indicated that Patient E was "negative" for benzodiazepines, despite being prescribed that drug by Respondent. However, Respondent never required Patient E to get another UDS and/or other confirmatory screen to confirm that he was taking the controlled medications being prescribed to him. Instead, Respondent continued to issue prescriptions for controlled pain medication to Patient E without documenting in the medical record any information and/or discussion with Patient E about the inconsistent UDS results.

(d) Patient E had a history of illicit drug use. However, Respondent never discussed and/or documented any discussion with Patient E in the medical record about any past history of illicit drug use.

25. Respondent committed repeated negligent acts in his care and treatment of Patient E including, but not limited to, the following:

(a) Respondent failed to require Patient E to get another UDS and/or other confirmatory screen to confirm that he was taking the controlled medications that Respondent had been prescribing to him; and

(b) Respondent failed to document in the medical record any discussion with Patient E about any past history of illicit drug use.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in his care and treatment of patient A, as more particularly alleged hereinafter:

27. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

28. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to patients A, B, and C, as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

29. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

30. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

31. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

32. Respondent has further subjected his Physician's and Surgeon's Certificate

No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

33. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

34. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

35. **Patient C**

(a) Paragraphs 15 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient D**

(a) Paragraphs 17, 18, and 23, above, are hereby incorporated by reference and realleged as if fully set forth herein.

37. **Patient E**

(a) Paragraphs 24 and 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

38. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or 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, as more particularly alleged in paragraphs 10 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 License No. G66777, issued to Respondent David James Smith, M.D.;

2. Revoking, suspending or denying approval of Respondent David James Smith, M.D.'s, authority to supervise physician assistants and/or advanced practice nurses;

3. Ordering Respondent David James Smith, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

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

DATED: February 13, 2019

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

SD2017802855
Doc.No.71736994

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

PHYSICIAN AND SURGEON

CERTIFICATE NO. **G66777** EXPIRATION **01/31/2019**

DAVID JAMES SMITH
 # 210
3703 CAMINO DEL RIO SOUTH
SAN DIEGO CA 92108

ORIGINAL ISSUANCE DATE
08/21/1989

RECEIPT NO.
100023954

703

DAVID JAMES SMITH
210
3703 CAMINO DEL RIO SOUTH
SAN DIEGO CA 92108

categories of public and disciplinary information on licensees, including links to other informational Web sites. This information is updated on a regular basis. The Board's Web site can be accessed on the Internet at **www.mbc.ca.gov**

Has your Address of Record changed?

your address changes prior to your next renewal, please be sure to inform the Board *in writing* of your new ddress. California law requires that you report your address change to the Board within 30 days of the change. If ne address of record you wish to report is a post office box (PO Box), the law requires that you provide a (separate) treet address. The timely reporting of your change of address to the Board ensures that any correspondence and ailings to you, such as your next renewal notice, continue uninterrupted. Change of Address forms can be ownloaded from the Board's Web site under Forms/Publications or at www.mbc.ca.gov/forms-pubs.html.

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- A post office box as the address of record to be listed for public information; however, a (separate) street address must also be provided to the Board which will be regarded as a confidential address; **OR,**
- Your employer's address, billing address or the address of a family member or friend. Please ensure that you receive permission from the appropriate party for the use of an address other than your own.

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Sacramento, CA 95815

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

CERTIFICATE NO. G66777 — PHYSICIAN AND SURGEON
EXPIRATION 01/31/2019

DAVID JAMES SMITH
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SAN DIEGO CA 92108

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ORIGINAL ISSUANCE DATE
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