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

In the Matter of the Accusation )
Against: )
 )
PHILIP JAMES MORGAN, M.D. ) Case No. 800-2013-000443
 )
Physician's and Surgeon's ) OAH No. 2016010148
Certificate No. G 56468 )
 )
Respondent )

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 1, 2017.

IT IS SO ORDERED January 30, 2017.

MEDICAL BOARD OF CALIFORNIA

By: Michelle Anne Bholat, M.D., Chair
Panel B
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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against:

PHILIP JAMES MORGAN, M.D.,
Physician’s and Surgeon’s Certificate No. G 56468,

Respondent.

Case No. 800-2013-000443
OAH No. 2016010148

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on October 31 and November 7 and 8, 2016, in Los Angeles.

Richard D. Marino, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department), State of California.

Henry Fenton and Nicholas Jurkowitz, Attorneys at Law, represented respondent Philip James Morgan, M.D., who was present.

Oral and documentary evidence was received. The record was closed and the matter was submitted on November 8, 2016.

Protective Order

Complainant filed a request for a protective order sealing all exhibits to protect confidential medical information of third parties; respondent made no objection. The ALJ issued a protective order dated December 8, 2016, sealing all exhibits. Redaction of those documents to obscure confidential information was not practicable and would not have provided adequate privacy protection. Those exhibits shall remain under seal and shall not be opened, except by order of the Board, by OAH, or by a reviewing court. The ALJ ordered that every court reporter refer in the hearing transcript to respondent’s patients by initials only.
Amendment to Accusation

During the hearing, the Accusation was amended on complainant’s unopposed motion, as follows: the Second Cause for Discipline (Prescribing to Addicts) (Ex. 1, Accusation, p. 29, lines 1 through 7) was deleted.

Factual Findings

Jurisdiction

1. Complainant filed the Accusation in her official capacity. Respondent timely filed a notice of defense.


Respondent’s Background

3. Respondent is in private practice in the field of pain management in Encino and Hawthorne, California. He attended medical school at Georgetown University School of Medicine from 1980 to 1982, and obtained his medical degree from the University of Southern California School of Medicine in 1984. He completed an internship in the Department of Surgery at Loma Linda University in 1984, an orthopedic rehabilitation clinical research fellowship at Rancho Los Angeles Hospital in Downey in 1985, an anesthesiology residency at Harbor-UCLA Medical Center in 1989, and a pain fellowship at UCLA Medical Center in 1990. He is a diplomate of the American Board of Anesthesiology, with a subspecialty certification in pain management.

The Board’s Investigation and Complainant’s Allegations

4. On October 23, 2013, a Walgreen’s pharmacist notified the Board that respondent might be overprescribing controlled substances to his patients.

5. William Boyd, an investigator with the Health Quality Investigation Unit of the Department’s Division of Investigation, investigated the complaint. Mr. Boyd obtained Controlled Substance Utilization Review and Evaluation System (CURES) reports and medical records for various patients of respondent’s, interviewed respondent and witnesses, and forwarded the information he had gathered to Standiford Helm, M.D., a Board expert consultant, for review. Based on Dr. Helm’s opinion, Mr. Boyd referred the matter to the Attorney General’s Office for review for possible disciplinary action.

6. Complainant alleges seven causes for discipline against respondent with respect to his treatment of each of those seven patients: for excessive prescribing of controlled substances (First Cause for Discipline); prescribing without medical indication or without performing an appropriate prior examination (Third Cause for Discipline); violation of drug statutes (Fourth Cause for Discipline); gross negligence (Fifth Cause for Discipline); repeated
negligent acts (Sixth Cause for Discipline); incompetence (Seventh Cause for Discipline); and
failure to maintain adequate and accurate medical records (Eighth Cause for Discipline).\(^1\)

**Respondent’s Treatment of Seven Patients from 2012 to 2014**

7. Patient MK was referred to respondent for pain management treatment by the
patient’s primary care physician in February 2013. Patient MK had sciatica and sacroiliac joint
pain.

a. On her first visit to respondent, in March 2013, she reported no history
of drug abuse, and no such history was evident in her records. Respondent did not obtain a
CURES report for Patient MK.\(^2\) Respondent’s notes from that visit reflect that Patient MK
presented with a four-month history of lower back pain; she showed lumbar tenderness,
significant pain behavior, a moderate antalgic gait, moderate depression, and minimal drug-
seeking behavior.\(^3\) She had been taking Ibuprofen and Gabapentin (an anti-seizure
medication often prescribed for neuropathic pain). She reported smoking but no use of
alcohol or non-prescription drugs. Respondent reviewed the patient’s x-rays; she had not yet
undergone an MRI. Respondent diagnosed Patient MK with a possible lumbar spine disc
herniation and radiculitis, an inflammation of the spinal nerve root. Patient MK was already
taking prescription Percocet.\(^4\) After verbally describing the ramifications and risks of opioid
use and obtaining Patient MK’s informed consent, respondent continued the Percocet
prescription of five milligrams, three times per day, which he described as the lowest
possible dose, and added a prescription for Voltaren (diclofenac), a non-steroidal anti-
inflammatory drug (NSAID), to replace the Ibuprofen Patient MK had been taking. In his
treatment plan he ordered Patient MK to increase her physical activity and take medication at
set times rather than as needed. Respondent also authorized a series of three epidural
injections. Respondent obtained a medication contract from Patient MK.

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\(^{1}\) The Accusation was amended at hearing to delete a Second Cause for Discipline for
prescribing to addicts.

\(^{2}\) CURES reports reflect a patient’s prescriptions for controlled substances.

\(^{3}\) On respondent’s Pain Management Consultation form, used for initial visits, and his
Pain Management Follow-up Opioid Management form, used for follow-up visits, there were
scales ranging from “none” to “profound” to indicate respondent’s clinical impressions of
each patient’s break-through pain, pain behaviors, situational depression, drug-seeking
behavior, and gait. (See, e.g., Ex. 24, p. 4.) Respondent abandoned the use of scales when he
began using electronic medical records.

\(^{4}\) Percocet is a combination of acetaminophen and oxycodone, an opioid pain
medication.
b. Patient MK received epidural injections on April 15, 22, and 29, 2013, and respondent prescribed an additional 15- or 30-day supply of Percocet each time. Respondent testified that the initial doses were minimal for treating sciatica, so he increased the dose at Patient MK’s request. He did not document the reasons for the increases in his progress notes.

c. Respondent saw Patient MK on May 28, 2013, and approximately every 30 days thereafter through October 2013. On May 28, respondent noted that Patient MK’s pain behaviors, situational depression, and drug-seeking behavior were all quite low; she still presented with moderate antalgic gait. On July 23, respondent noted that the patient’s situational depression had increased significantly. On August 20, respondent described Patient MK’s depression as “profound;” her breakthrough pain and pain behaviors were moderate. On September 17, respondent noted that the patient’s situational depression was moderate; on October 22, he noted that the patient’s pain behaviors and situational depression were high; the patient presented with foot drop, and respondent referred her for a consult on that condition.

d. Patient MK stopped seeing respondent after the October 2013 visit, and began receiving treatment and opioid prescriptions from another physician; she was also under the care of a nurse practitioner. She died in April 2014, six months after she last visited respondent, from malnutrition and cardiac arrest.

8. Patient LA was seen by respondent on November 26, 2012, on a follow-up visit. The evidence does not establish the date of her referral or first visit to respondent.

a. Respondent’s follow-up visit notes show that he had diagnosed Patient LA with lumbosacral radiculitis and a herniated lumbar disc. Respondent noted that the patient had moderate depression, minimal drug-seeking behavior, and a mild antalgic gait. Respondent renewed the patient’s prescription of diclofenac and Norco (a combination of hydrocodone, an opioid, and acetaminophen), and authorized a follow-up visit in 30 days.

b. On visits between January 7 and August 18, 2013, the Norco prescription was replaced by a Vicodin prescription. Respondent reported varying levels of break-through pain and pain behaviors for Patient LA, ranging over the course of her visits from low to very high. In November 2013, respondent noted that Patient LA was being seen by a rheumatologist for lupus, an autoimmune disease that attacks joints. The patient’s break-through pain was constant, her pain behaviors and situational depression were very high, and she walked with a moderate antalgic gait; her drug-seeking behavior was low. He replaced the Vicodin with increased doses of Norco to address Patient LA’s increased pain, which appeared in the note’s pain scales. He also replaced the diclofenac with meloxicam and prescribed Gabapentin.

c. In February, March, and May 2013, and again between November 2013 and February 2014, respondent ordered epidural steroid injections for Patient LA to avoid surgery and reduce her level of pain. Respondent did not include in his follow-up notes the reason for ordering the epidural injections, but he incorporated in his chart on Patient LA a
January 9, 2012, lumbar MRI report from Stanton H. Joe, M.D., stating that the patient’s lumbar spine showed a 5 millimeter disc herniation that was pinching the patient’s nerve roots. Respondent testified that this condition is a classic indication for a lumbar injection.

9. Patient AM was referred for treatment to respondent for pain management. Her initial consultation with respondent occurred on August 19, 2013. On that date, she signed a medication contract describing respondent’s guidelines for the prescription of pain medications.

a. Patient AM presented with severe knee pain; she had had surgery on both knees since suffering an accident in 2008, but was too young to be a candidate for knee replacement. She also had lupus. Patient AM had been prescribed Soma, a barbiturate muscle relaxant, and Norco by her primary care physician. Respondent continued to prescribe Soma for Patient AM; he noted that his plan was to taper the Soma, and testified that it would have been dangerous to suddenly stop the Soma prescription, as that could cause seizures. Respondent saw nothing in the patient’s record to warrant obtaining a CURES report for her. He prescribed Norco for 30 days on August 19, 2013, recording that her pain behavior and depression levels were very high.

b. On September 23, 2013, respondent noted that Patient AM experienced constant knee pain, moderate break-through pain, significant situational depression, and moderate drug-seeking behavior. He prescribed the lowest possible dose, 15 mg., of MS Contin, an extended-release formulation of oral morphine, to be taken every 12 hours. On subsequent visits on October 22, November 19, and December 19, 2013, respondent noted break-through pain ranging from moderate to high, and pain behaviors and situational depression ranging from moderate to profound. He continued the prescriptions for Soma, Norco, and MS Contin and, on December 19, 2013, authorized a rheumatology consult. Respondent testified that he prescribed MS Contin because Patient AM had only been taking short-acting medications; she was experiencing increasing pain, especially at night, and respondent wanted to counteract her break-through pain to allow her to sleep. He varied the dosage of MS Contin over several visits based on the information reflected in the break-through pain, pain behaviors, depression, and gait scales reflected in his notes. He authorized the rheumatology consult because the patient required treatment for lupus. The notes for each visit reflect a plan to reassess in 30 days.

10. Patient HT was referred for treatment to respondent, who first saw her on March 15, 2012. She reported neck, arm, and lower back pain, had a 10-year history of neck and upper extremity pain, and had had a cervical MRI in 2007, showing a herniated disc in her neck. She was taking Vicodin and Soma, as well as Ibuprofen. Respondent noted a degree of opioid tolerance. He prescribed MS Contin and renewed the prescriptions for Vicodin, at a lower dose, and Soma. Respondent also authorized a cervical epidural, and had the patient sign a medication contract.

a. Patient HT had three cervical epidural steroid injections, on April 3, April 9, and April 16, 2012. At the time of the first injection, respondent prescribed 60 tablets of Vicodin; at the time of the third injection, respondent prescribed 90 tablets each of
Norco and Soma. There is no explicit explanation for the dose increase in respondent’s procedure notes; respondent testified that he had only recently started the patient on the extended-release MS Contin and that it is common to increase the short-acting Vicodin until the MS Contin takes effect and the patient no longer needs the same dose of Vicodin. Respondent refilled the prescriptions on May 14, 2012. On June 4, 2012, respondent decreased the Soma dose, annotating a plan to taper the medication.

b. On June 14, respondent noted a mild opioid dependence and planned to taper Patient HT. He reduced the patient’s Soma dosage on July 12, 2012. Her medications were continued over the course of monthly follow-up visits through April 2013. In April and May 2013, the patient had three additional cervical epidural steroid injections. Her medications were continued, with the addition of Mobic, an NSAID, and Zanaflex, a short-acting muscle relaxant to substitute for the Soma, in July 2013. Respondent added those prescriptions to help minimize neck pain and help the patient sleep through the night, and thereby reduce the need for narcotics. He testified that his strategy should be obvious to a physician who understands pain management. She reported the theft of her purse and medications in August 2013; respondent maintained her medications in September and October 2013.

c. In November and December 2013, Patient HT received three additional epidural steroid injections and was given Norco, Soma, and Percocet at varying doses, with varying degrees of pain indicated in respondent’s notes.

d. After a lumbar MRI in January 2014, respondent authorized three epidural steroid injections, which the patient received in March 2014, and renewed the patient’s medications. Through June 2014, respondent saw Patient HT every month, noting her pain, depression, and gait on the scales in his notes, and adding diclofenac in June 2014. In July 2014, respondent authorized three additional epidural injections and refilled the patient’s Norco prescription.

11. Patient OS was referred for treatment to respondent on October 17, 2011.

a. The patient had a five-month history of shoulder, elbow, and knee pain, and he was taking Lortab, a combination of hydrocodone and acetaminophen, daily. Respondent noted that the patient was an alcoholic, with episodic pain due to gout. Respondent diagnosed the patient with degenerative joint disease, gout, and chronic intractable pain, and prescribed Norco or Vicodin monthly. Patient OS signed a medication contract with respondent on February 2, 2012.

b. After regular monthly visits, in October 2012, respondent added a diagnosis of post-lumbar laminectomy syndrome, prescribed MS Contin, and discontinued the acetaminophen. Respondent also discontinued diclofenac, due to renal issues, and continued to see the patient periodically. In the notes of an August 2014 visit, respondent increased the MS Contin dose. By that time, it was easier for physicians to obtain CURES reports, and respondent obtained a CURES report for Patient OS. A July 17, 2014, report showed that the patient had obtained prescriptions for Norco and Dilaudid (hydromorphone,
an opioid). The doses indicated were very low, and the patient told respondent the medications had been prescribed by the patient’s dentist for a root canal; respondent concluded that the CURES report did not show habitual opioid abuse.

c. Respondent continues to treat Patient OS. The patient uses Tramadol and no longer uses morphine.

12. Patient BC was referred for treatment to respondent on May 7, 2013. She was experiencing lower back pain since having stepped into a manhole several years earlier, and was taking Percocet three times per day. Respondent diagnosed Patient BC with lumbosacral radiculitis and a herniated lumbar disc. The patient signed a pain agreement, and had three epidural steroid injections between May and July 2013 to bring the pain under control. Respondent continued to refill the patient’s Percocet prescriptions every month through November. Patient BC’s pain was noted to have increased in December, and she received three additional epidural injections, in January, February, and March 2014. In an August 22, 2014, progress note, respondent noted that the patient’s pain had decreased by 70 percent, and he tapered her from 10 mg to 5 mg of Percocet. A urine drug screen (UDS) in July 2014 showed Patient BC as negative for opioids but positive for methadone; based on the UDS result, respondent discharged the patient.

13. Patient CC was referred for treatment to respondent by her primary care physician in February 2012. She had lupus for 16 years, since age 14, and was experiencing pain in her large muscle groups and joints. Respondent’s plan was to medically manage her pain. Respondent maintained her on Flexeril, a muscle relaxant, Norco, and Tramadol, and added diclofenac. Patient CC signed a medication contract. On March 28, 2012, respondent added MS Contin, to be taken at night; he saw the patient periodically thereafter on a roughly monthly basis, occasionally changing or tapering her medications and ordering epidural injections, based on the pain the patient was experiencing as reflected in the various scales in respondent’s notes. Respondent testified that his goal was to have Patient CC on the lowest doses possible while maximizing her functional abilities. In November 2013, respondent prescribed Percocet; he decreased the dose in January 2014.

Expert Witnesses

14. Complainant offered the testimony of Standiford Helm, M.D., to establish the standard of care for the treatment of the seven patients in this case. Dr. Helm is Medical Director of the Helm Center for Pain Management in Laguna Hills, California, which treats patients with subacute and chronic pain. He received his medical degree from Tufts University in 1977, completed an internship in internal medicine at Boston City Hospital in 1978, and completed an anesthesiology residency at UCLA in 1980. He is licensed in California and has been a diplomate of the American Board of Anesthesiology since October 1982, with a subspecialty certification in pain medicine that expires in 2023. He is also a diplomate of the American Board of Pain Medicine since 1993 and of the American Board of Interventional Pain Physicians since 2006. Dr. Helm is a qualified medical evaluator for the Board. He has provided
pain management treatment to, by his estimate, tens of thousands of patients. He is on the medical staff at various medical centers in Orange County.

15. Respondent offered the testimony of Jack Marshall Berger, M.S., M.D., Ph.D., to establish the standard of care for the treatment of the seven patients in this case. Dr. Berger is a Clinical Anesthesiology Professor in the Department of Anesthesiology at the Keck School of Medicine at the University of Southern California, where he teaches pain management to residents and fellows. He was an associate professor there from 1995 to 2007, and served as the Clinical Director of Pain Management there from 1995 to 2000. He received his medical degree from the University of Bologna, Italy, in 1978, completed internships at the University of Bologna in anesthesiology and other fields in 1978 and in pediatrics at the University of Southern California Medical Center in 1980, and completed his residencies in anesthesiology at the University of Southern California Medical Center in 1981 and at UCLA Medical Center in 1982. He is licensed to practice medicine in California. He has been a diplomate of the American Board of Anesthesiology since 1984 and has been certified in the subspecialty of pain management since 1994; the certification was renewed and expired on December 31, 2014. He is also a diplomate of the American Academy of Pain Management. He continues to practice in the field of pain management.

16. Drs. Helm and Berger were qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert’s testimony over the other’s was based on the content of their testimonies and the bases for their opinions, as set forth below.

Standard of Care for the Treatment of the Seven Patients

17. Dr. Helm testified that the standard of care is what a reasonable trained physician in the community would do under similar circumstances.

18. Inspector Boyd sent documents regarding respondent’s treatment of the seven patients to Dr. Helm for his expert review. Dr. Helm opined that respondent departed from the standard of care in his treatment of the seven patients, as follows.

19. With respect to Patient MK:

a. Respondent’s intake history and physical examination was perfunctory, lacking a discussion of the patient’s pain, the need for the use of opioids, or earlier prescriptions, and constituted an extreme departure from the standard of care.

b. Respondent’s treatment plan lacked documentation as to whether the epidurals ordered and medications prescribed were effective and how to evaluate their effectiveness, and constituted an extreme departure from the standard of care.

c. There was no indication of periodic review of respondent’s opioid prescriptions, and brief periodic visits were insufficient to assess the appropriateness of the prescriptions, constituting an extreme departure from the standard of care.
d. Respondent’s medical records do not provide a rationale for his treatment plans and changes in treatment, constituting a simple departure from the standard of care.

e. Respondent overprescribed opioids, based on information in the medical records, constituting an extreme departure from the standard of care.

20. With respect to Patient LA:

a. Respondent’s records indicate poor periodic review, providing no documentation of the patient’s response to opioids, functional improvement, side effects, or abuse, or rationale for changes in dosing, constituting an extreme departure from the standard of care.

b. Respondent’s medical records do not indicate why the treatment plan changed, and why medication doses changed, and what effect the epidurals had on the patient’s pain and functioning, constituting an extreme departure from the standard of care.

21. With respect to Patient AM:

a. Respondent’s history and physical examination is limited, with no discussion of the patient’s pain, physical and psychological functioning, substance abuse history, history of prior pain treatment, assessment of underlying diseases and conditions, or any indication for the use of a controlled substance, constituting an extreme departure from the standard of care.

b. Respondent’s treatment plan does not track outcomes, and medication doses are changed without explanation, constituting an extreme departure from the standard of care.

c. Respondent did not perform a periodic review of the effects of his treatment, providing no information regarding the patient’s progress in his notes, constituting an extreme departure from the standard of care.

d. Respondent prescribed Soma for the patient without indicating a medical reason for its use, constituting a simple departure from the standard of care.

22. With respect to Patient HT:

a. Respondent’s history and physical examination, treatment plan, objectives, and informed consent were overly cursory, and constituted a simple departure from the standard of care.

b. Respondent’s periodic review, reflecting no explanation for changes in medication or doses, and his failure to obtain CURES reports, constituted an extreme departure from the standard of care.
23. With respect to Patient OS
   a. Respondent’s history and examination contained minimal information, lacked an explanation for his diagnoses, and lacked an explanation for opioid prescriptions, constituting an extreme departure from the standard of care.
   b. Respondent did not monitor the patient’s functional improvement or pain relief and did not consult a CURES report, constituting an extreme departure from the standard of care.

24. With respect to Patient BC, deficiencies in respondent’s monitoring of the effectiveness of prescribed opioids and his failure to obtain a CURES report constituted a simple departure from the standard of care.

25. With respect to Patient CC, respondent failed to document monitoring of the efficacy of his treatments and did not obtain a CURES report until 2014, constituting a simple departure from the standard of care.

26. Dr. Berger opined that respondent did not depart from the standard of care in his treatment of the seven patients.

27. With respect to Patient MK, the patient’s charts, including the referring note and the notes of respondent’s examination, were extensive and complete and more than sufficient to justify respondent’s pain management treatment of the patient. Respondent documented his clinical assessment of the patient’s pain behavior, gait, and symptoms, and the medications the patient was already taking. Obtaining a CURES report was not the standard of care in 2012 or 2013, unless abuse was suspected and drug-seeking behavior was demonstrated; few physicians had access to those reports, and Patient MK did not display significant drug-seeking behavior. Respondent’s authorization of epidural injections was indicated by the patient’s presentation and radiculitis diagnosis; epidurals, if successful, might allow a reduction or elimination of the opioid prescriptions, and provide a fairly good predictor for surgical outcomes.

28. With respect to Patient LA, respondent’s notes are sufficient to explain the course of care. The patient’s break-through pain level, pain behaviors, and depression, reflected in scales on each note, were significant and justified the changes in medication and doses and the series of epidural injections. According to Dr. Berger, the records would be clear to a reviewing physician, though he did not seem confident about this, and his opinion on this matter only is not given much weight. The patient’s chart included a prior MRI examination, and respondent would be expected to have reviewed that without rewriting it in his own notes. The patient’s records include all required written consents. The patient’s reaction to her treatment is repeatedly evaluated and reflected in the pain scale and other scales. The absence of a CURES report is not a deviation from the standard of care.

29. With respect to Patient AM, as with the other patients, a verbal discussion of the risks of opioid use was the standard of care for informed consent, along with a medication contract, which respondent used. The patient was taking Soma when she presented to
respondent, and weaning a patient off Soma is a slow and difficult process. There was no indication of a need for a CURES report, as Patient AM's records do not indicate she was drug-shopping. From the patient's records, the reason for respondent's use of MS Contin is evident; for a patient with lupus degenerative knee joint disease, and chronic knee pain, an extended-release opioid is required to overcome constant pain and to allow other medications to take effect. The referral to a rheumatologist was appropriate for a patient with lupus. Reasons for changes in medication doses are provided in the scales respondent used in his notes. The patient's progress and respondent's monitoring of the effectiveness of the medications are evident in the notes as well.

30. With respect to Patient HT, respondent's notes, in particular the scales, provide the rationale for changes in doses and medications, with some exceptions. Tapering the patient's doses of Soma was appropriate. The use of Mobic and Zanaflex as adjunctive medications was adequately explained. The objective, decreased pain, was presented in respondent's notes. Respondent identified possible drug-seeking behavior by Patient HT and closely monitored the patient thereafter, which was entirely within the standard of care.

31. With respect to Patient OS, treating a patient who suffers from degenerative joint disease, gout, and chronic intractable pain with opioids is within the standard of care. The records are not sparse, as complainant charges. They indicate why opioids are prescribed, why diagnoses are added, and that respondent thoroughly monitored Patient OS and the effectiveness of his treatment, using scales.

32. With respect to Patient BC, respondent obtained an appropriate informed consent, and nothing in the medical records deviates from the standard of care.

33. With respect to Patient CC, who presented with lupus, a chronic painful disease lasting the patient's lifetime, respondent provided progress notes, periodic review, and medical indication for medication, epidurals, and tapering consistent with the standard of care.

34. Regarding whether respondent engaged in excessive prescribing, prescribing without medical indication or without performing an appropriate prior examination, violations of drug statutes, gross negligence, repeated negligent acts, and incompetence, the opinions of Dr. Berger, coupled with the respondent's testimony and the documentary evidence, were more persuasive than the opinions of Dr. Helm. Therefore, the opinions of Dr. Berger on these causes for discipline, as set forth in Factual Findings 26 through 33, are adopted as facts herein, except where stated otherwise. Regarding whether respondent failed to maintain adequate and accurate medical records and departed from the standard of care, the opinions of Dr. Berger, set forth in Factual Findings 19 through 25, were more persuasive and are adopted as facts herein, except where stated otherwise.

Character Evidence

35. Kevin Thomas, M.D., testified on respondent's behalf. Dr. Thomas is a general practitioner in a group practice, the Florence Western Medical Clinic. He and other doctors in his medical group refer many patients to respondent for pain management; those patients have
provided positive feedback about respondent. Respondent has a reputation for being strict about prescribing medicine to treat pain. Dr. Thomas has had no reservations about continuing to refer patients to respondent.

Mitigation and Rehabilitation

36. Respondent testified that his treatment of the seven patients has been appropriate for the conditions they presented with, and that he took appropriate histories and developed appropriate treatment plans for those patients. His testimony was, for the most part, persuasive, as corroborated by Dr. Berger and by the documentary evidence.

37. Respondent's record-keeping practices, however, were not consistently defensible using the applicable standard of care. Some annotations could only be interpreted by a pain specialist, and not by a general practitioner or other specialist who might be reviewing the patient files, and some notes were incomplete or lacking sufficient information to explain every prescription or change in dosage. They leave a good deal of detail unstated. Respondent has changed his recordkeeping practices. After learning of the Board's investigation, respondent, through his counsel, retained Dr. Berger to advise him on electronic recordkeeping, among other things. Respondent adopted Dr. Berger's suggestions and believes his current recordkeeping practices are significantly improved.

LEGAL CONCLUSIONS

Burden of Proof


Applicable Authority

2. The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) The Board may take action against a licensee for unprofessional conduct, which includes gross negligence, repeated negligent acts, and incompetence. (§§ 2234, subds. (b), (c), & (d).)

3. A licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or "other action taken in relation to

5 Further statutory references are to the Business and Professions Code except where otherwise stated.
discipline" as the Board deems proper. (§ 2227.) Among those other actions listed is public reprimand of the licensee. (§ 2227, subd. (a)(4).)

4. In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the “recognized and approved methods.” (Callahan v. Hahnemann Hospital (1934) 1 Cal. 2d 447.) Negligence is not shown by evidence that other medicines or treatment might have been employed. (Jensen v. Findlay (1936) 17 Cal.App. 2d 536.) The mere fact that there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish that the determination to use one of the procedures was negligent. (Clemens v. Regents of Univ. of Cal. (1970) 8 Cal.App. 3d 1, 13.)

Cause for Discipline

5. Cause does not exist to suspend or revoke respondent’s license under section 725, in that clear and convincing evidence did not establish that he excessively prescribed controlled substances and other dangerous drugs, as set forth in Factual Findings 4 through 37.

6. Cause does not exist to suspend or revoke respondent’s license under section 2242, in that clear and convincing evidence did not establish that he prescribed controlled substances and other dangerous drugs without medical indication and without performing an appropriate prior examination, as set forth in Factual Findings 4 through 37.

7. Cause does not exist to suspend or revoke respondent’s license under sections 2238, 725, 2241, and 2242, and Health and Safety Code sections 11152, 11153, and 11190, in that clear and convincing evidence did not establish that he violated applicable drug statutes, as set forth in Factual Findings 4 through 37.

8. Cause does not exist to suspend or revoke respondent’s license under section 2234, subdivision (b), in that clear and convincing evidence did not establish that he committed gross negligence during his care, treatment, and management of patients, as set forth in Factual Findings 4 through 37.

9. Cause does not exist to suspend or revoke respondent’s license under section 2234, subdivision (c), in that clear and convincing evidence did not establish that he committed repeated negligent acts during his care, treatment, and management of Patients MK, LA, AM, HT, OS, BC, and CC, as set forth in Factual Findings 4 through 37.

10. Cause does not exist to suspend or revoke respondent’s license under section 2234, subdivision (d), in that clear and convincing evidence did not establish that he lacks the education, skill, and knowledge to treat patients suffering from addiction and substance abuse, as set forth in Factual Findings 4 through 37.

11. Cause exists to suspend or revoke respondent’s license under section 2266, in that clear and convincing evidence established that he failed to prepare and maintain adequate
and accurate medical records relating to the provision of care to Patients MK, LA, AM, HT, OS, BC, , and CC, as set forth in Factual Findings 4 through 37.

12. Complainant established respondent’s failure to maintain adequate and accurate medical records, and that cause for discipline exists. The Board must acknowledge to both the public and the medical community that respondent’s recordkeeping practices in 2012 and 2013 were not in compliance with the Business and Profession Code. The question is the nature of the discipline to be imposed against respondent’s certificate. In view of all the evidence, including evidence of respondent’s efforts to change his recordkeeping practices to conform to the standards of the profession, and complainant’s failure to clearly and convincingly establish that respondent cannot practice medicine in a safe and proper manner, the safety of the public will be protected if respondent is issued a public reprimand, under section 2227, subdivision (a)(4). The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (Camacho v. Youde (1979) 95 Cal.App.3d 161, 164; Small v. Smith (1971) 16 Cal.App.3d 450, 457.) While some form of discipline is warranted to ensure public safety and awareness, in this case neither revocation nor Board oversight through probation is appropriate. License revocation or suspension would be unduly punitive, and the probation conditions set forth in the disciplinary guidelines are unnecessary under the circumstances presented, with one exception. A public reprimand and an order that respondent enroll in and successfully complete a medical record keeping course will best protect the public without imposing overly harsh and punitive discipline on respondent.

ORDER

Respondent Philip James Morgan, M.D., is hereby reprimanded under Business and Professions Code section 2227, subdivision (a)(4).

Respondent is ordered as follows:

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent’s initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course
would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

DATED: December 8, 2016

[Signature]

HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearing
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Philip James Morgan, M.D.
16500 Ventura Blvd., Suite 375
Encino, CA 91436

Physician's and Surgeon's Certificate
No. G 56468,

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
capacity as the Executive Director of the Medical Board of California, Department of Consumer
Affairs, State of California (Board).

2. On or about December 2, 1985, the Board issued Physician's and Surgeon's
Certificate Number G 56468 to Philip James Morgan, 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 June 30, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following
laws. All section references are to the Business and Professions Code unless otherwise indicated.
4. Section 2227 of the Code provides:

"(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."

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

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

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

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

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

" . . . 

6. Section 2238 of the Code provides:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 2241 of the Code provides:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a
person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. Section 2242 of the Code provides:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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

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

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

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

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

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

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

9. Section 2266 of the Code provides:

"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."

10. Section 725 of the Code, in pertinent part, provides:

"(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.

“...”

11. Health and Safety Code section 11152 provides:

“No person shall write, issue, fill, compound, or dispense a prescription that does not
conform to this division.”

12. Health and Safety Code section 11153, in pertinent part, provides

“(a) A prescription for a controlled substance shall only be issued for a legitimate
medical purpose by an individual practitioner acting in the usual course of his or her
professional practice. The responsibility for the proper prescribing and dispensing of
controlled substances is upon the prescribing practitioner, but a corresponding
responsibility rests with the pharmacist who fills the prescription. Except as authorized by
this division, the following are not legal prescriptions: (1) an order purporting to be a
prescription which is issued not in the usual course of professional treatment or in
legitimate and authorized research; or (2) an order for an addict or habitual user of
controlled substances, which is issued not in the course of professional treatment or as part
of an authorized narcotic treatment program, for the purpose of providing the user with
controlled substances, sufficient to keep him or her comfortable by maintaining customary
use.

“...”

13. Health and Safety Code section 11190, in pertinent part, provides:
"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

"(1) The name and address of the patient.

"(2) The date.

"(3) The character, including the name and strength, and quantity of controlled substances involved.

"(b) The prescriber’s record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

"(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

"(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

"(B) The prescriber’s category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

"(C) NDC (National Drug Code) number of the controlled substance dispensed.

"(D) Quantity of the controlled substance dispensed.

"(E) ICD-9 (diagnosis code), if available."
“(F) Number of refills ordered.

“(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

“(H) Date of origin of the prescription.

“(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

“(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

“(d) This section shall become operative on January 1, 2005.

“(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

“(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

“(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

“(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

“(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

“(2) The administration or dispensing of a controlled substance in accordance with
any other exclusion identified by the United States Health and Human Service Secretary for
the National All Schedules Prescription Electronic Reporting Act of 2005.”

**CONTROLLED SUBSTANCE/DANGEROUS DRUGS**

14. The following medications are controlled substances and dangerous drugs within
the meaning of the Health and Safety Code and Business and Professions Code:

A. Oxycodone - is an opioid pain medication. An opioid is sometimes called
a narcotic. Oxycodone is used to treat moderate to severe pain. Oxycodone extended-
release is used for around-the-clock treatment of pain. This form of oxycodone is not for
use on an as-needed basis for pain.

B. Voltaren - (diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID).
This medicine works by reducing substances in the body that cause pain and inflammation.
Voltaren is used to treat pain or inflammation caused by arthritis or ankylosing spondylitis.

C. Percocet - a combination of acetaminophen and oxycodone. Oxycodone is
an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a
less potent pain reliever that increases the effects of oxycodone. Percocet is used to relieve
moderate to severe pain.

D. Lidocaine - also known as xylocaine or lignocaine, is a medication used to
freeze tissue in a specific area and to treat heart arrhythmias. Lidocaine cream is also used
relieve itching, burning, and pain from skin inflammations.

E. Dilaudid (hydromorphone) - is an opioid narcotic pain-reliever similar to
oxycodone, morphine, methadone, fentanyl, and other opioids. Hydromorphone, like other
opioids, stimulates receptors on nerves in the brain to increase the threshold to pain
(increasing the amount of stimulation it takes to feel pain) and reduce the perception of pain
(the perceived importance of the pain).
F. Morphine - is used to relieve moderate to severe pain. It belongs to the
group of medicines called narcotic analgesics (pain medicines). Morphine acts on the
central nervous system (CNS) to relieve pain.

G. Vicodin - is used to relieve moderate to severe pain. It contains a narcotic
pain reliever (hydrocodone) and a non-narcotic pain reliever (acetaminophen).

H. Zanaflex - is a short-acting muscle relaxer.

I. Norco - contains a combination of acetaminophen and hydrocodone.

Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic.

Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone.

Norco is used to relieve moderate to severe pain.

J. Soma - (carisoprodol) is a muscle relaxer that works by blocking pain
sensations between the nerves and the brain.

K. MS Contin - is a brand of a time-released formulation of morphine sulfate,
usually taken every twelve hours for chronic pain.

L. Depo-medrol - is an anti-inflammatory glucocorticoid for intramuscular,
 intra-articular, soft tissue or intralesional injection. It is available as single-dose vials in
two strengths: 40 mg/ml, 80 mg/ml.

M. Lortab - used to relieve moderate to severe pain. It contains a narcotic pain
reliever (hydrocodone) and a non-narcotic pain reliever (acetaminophen). Hydrocodone
works in the brain to change how your body feels and responds to pain. Acetaminophen
can also reduce a fever.

N. Tramadol - used to help relieve moderate to moderately severe pain.

Tramadol is similar to narcotic analgesics.

O. Mobic - (meloxicam) - a nonsteroidal anti-inflammatory drug (NSAID).
Meloxicam works by reducing hormones that cause inflammation and pain in the body. Mobic is used to treat pain or inflammation caused by osteoarthritis or rheumatoid arthritis in adults and children who are at least 2 years old.

**STANDARD OF CARE**

15. A physician and surgeon must periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

16. The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

17. A physician and surgeon must keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

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18. Respondent is subject to disciplinary action under Business and Professions Code section 725 in that he excessively prescribed controlled substances and other dangerous drugs for Patients M.K., L.A., A.M., H.T., O.S., B.C., and C.C., as follows:

Patient M.K.

A. On or about February 27, 2013, M.K. requested a pain management evaluation from her primary physician due to a two month history of low back pain with sciatica, resulting in several emergency room visits. The primary physician’s notes indicate that he/she did not have access to imaging or ER notes. The physician provided Flexeril and ibuprofen and referred M.K to Respondent. The primary physician’s records for M.K. show that she was not taking any scheduled medications.

B. Respondent first saw M.K. on March 25, 2013, for low back and right radicular pain. On her intake form for Respondent, M.K. wrote that she was taking gabapentin, ibuprofen and oxycodone/acetaminophen 5/325 #3/day. Her pain diagram indicated right buttock and lateral thigh pain. The consult indicates that she did not have any history of drug abuse. Imaging, type not legible, was described as non-diagnostic. The gait was described as moderately antalgic. The DTRs were described as 5/5 (sic). She was diagnosed as having L5 radiculitis. She was provided Percocet 5/325 #2/day and recommended to have three lumbar epidural steroid injections. She was started on Voltaren. Respondent did obtain a “medication contract” dealing with use of the medication but not side effects.

C. Respondent provided interlaminar epidural injections on April 15, 2013. The procedure was not documented in Respondent’s records. M.K. was given another 30 tablets of Percocet two weeks after having received a month’s supply--another 30 tabs. It is not

1 All patients are referred to by their initials in order to protect their privacy rights. The true names of the patients are known to Respondent and, in any event, will be disclosed to him upon his timely written request for discovery.
clear whether she needed to be increased on her dosage to tid or whether she had already consumed her script from March 25, 2013.

D. On April 22, 2013, Respondent provided another interlaminar epidural injection and provided Percocet #90. Respondent’s records do not show why the Percocet was increased.

E. On April 29, 2013, M.K. had a third lumbar interlaminar epidural injection and again was provided more Percocet. As before, Respondent’s records do not show why the patient needed another month’s dosage of narcotics.

F. M.K. was next seen on May 28, 2013, and was provided Percocet and Voltaren. There was no assessment as to the efficacy of her treatment regimen. There was no mention of side effects, including GI upset from the NSAID. There is no documentation of pain ratings or functional status. Respondent noted the patient to have minimal pain behaviors, no situational depression and no drug seeking behavior.

G. The patient continued to be seen on roughly monthly intervals and was maintained on the same medication level. On September 1, 2013, she was to have an ankle foot orthosis (AFO). Respondent requested a lumbar MRI and a neurology consult.

H. The patient’s last visit was on October 22, 2013. She was noted to have been hospitalized for peptic ulcer disease. Voltaren was stopped at that point.

I. Respondent noted that M.K. was getting opioids from an A.C., M.D., on January 14, 2014, even though Respondent last saw her in October, 2013.

J. M.K. passed away on April 7, 2014, from malnutrition and a cardiac arrest. She had a gastrocutaneous fistula and was documented on the autopsy form as having a history of heroin abuse. At the time of her death, she weighed 66 pounds, with a height of 66 inches. Her toxicology at autopsy showed what were described as “not at lethal levels” of lidocaine, hydromorphone and morphine. The coroner felt that it was not possible to prove a link between her ulcer and her medication usage. The death was felt to be natural.

According to the interview with the patient’s father, M.K. had abused heroin since the death of her mother in 2007 and had transitioned to abusing prescription medications.
K. A medical history and physical examination must be taken of all patients. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance. However, the complexity of the history and physical examination will vary based on the practice location. In the emergency department, the operating room, at night or on the weekends, for example, the physician and surgeon may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the physician and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.²

L. Respondent’s medical history for, and physical examination of, Patient M.K. was perfunctory. Nothing in the patient’s examination or pre-evaluation intake form suggests the L5 radiculopathy. Other than a mention of the chief complaint and the social history, the examination lacks any discussion of pain or physical function or the documentation of the need for the use of opioids. There is a conflict between Respondent’s notes and the primary care practitioner’s notes as to whether M.K. was taking opioids. This conflict could have been resolved by a CURES report. Respondent did not review a CURES report or, in the alternative, did not document that he did so.

M. M.K.’s customer profile from Rite Aid shows that in February 2012, she received Vicodin 5/500 #30; in August 2012, Norco 7.5/325 #30 and Vicodin #15 in September 2012; Vicodin #15 in October, November and December 2012; Percocet 5/325 #15 in January 2013; and, Norco 5/325 #15 and Percocet 10/325 #20 in March 2013.

N. M.K.’s customer profile from Walgreen’s showed additional Vicodin prescriptions being received in August and October 2012.

O. There was no reason or rationale for the epidural injections noted in Respondent’s medical records for M.K.

² The prescribing of controlled substances for pain may require referral to one or more consulting physicians.
P. Patient M.K. exhibited drug seeking behavior which Respondent ignored.

Patient L.A.

Q. Although L.A., a 56-year-old female, had been Respondent’s patient prior to November 26, 2012, he had no records for her.³

R. Respondent’s undated intake form noted a two year history of low back pain “behind neck down right leg.” Her pain diagram showed neck/trapezius pain, paralumbar pain and left lateral thigh pain.

S. Respondent’s first available progress note is dated November 26, 2012. She had diagnoses of lumbosacral radiculitis and herniated disc lumbar. She was on diclofenac and Norco. She had moderate situational depression and less drug seeking behavior. She had an antalgic gait and did not use an assistive device. She had no clinical change and there is an “adequate medication profile.”

T. Patient L.A.’s next note is dated January 7, 2013, and documents a cervical epidural (CSEB) x3 done 3 years ago, with “excellent relief, now back.” Respondent prescribed Vicodin 7.5/500 #60.

U. Patient L.A. next presented on February 4, 2013. Eight days later, on February 12, 2013, she had a lumbar epidural steroid injection. A second lumbar epidural steroid injection was performed on March 21, 2013, and Vicodin 7.5/500 #60 was provided. A third lumbar epidural steroid injection was done on May 7, 2013. As with the previous injections, the site of service can be identified. The Vicodin prescription was refilled.

V. Respondent’s records show that Patient L.A. was next seen on June 6, 2013. Respondent’s note for that visit appears to document a lumbar epidural injection with 60% relief with some illegible right sided complaints. Physical therapy for the low back was requested. She declined a surgical referral.

W. She was seen again on August 8, 2013. She was switched, without explanation, to Norco 10/325 #90, an increase of both narcotic quantity and strength.

³ Respondent advised that the records were lost.
X. On November 19, 2013, she was given Norco 10/325 qid and gabapentin. Her note of this date indicates that she had, or will have, a rheumatology work up for an illegible reason. The note also documents a good response to the previous epidural and she needed a repeat injection. The increase in her medications was noted, but not explained.

Y. Adjacent to the November 19, 2013, prescription, the patient’s records contain a lumbar MRI, dated January 9, 2012, obtained at the request of M.M., MD. This exam shows a 5 mm disc bulge at L4-5 with bilateral mild-moderate foraminal narrowing and a 4 mm L5-S1 left-sided disc bulge with moderate left foraminal stenosis. There is no indication in Respondent’s notes that he saw this exam.

Z. There is a consent for a lumbar ESI on December 3, 2013. No procedure note is attached. There is a procedure note for lumbar ESI #2 on December 31, 2013. She had a 3rd lumbar epidural injection on February 25, 2014. There is no indication as to the rationale for this procedure; there is no indication in any of the procedure notes as to why the procedures were being done. She was given Norco 10/325 #180, again with no explanation as to why the dose was increased. The records contain an authorization form, dated December 24, 2013, which noted that the patient had a 60% decrease in pain from the second epidural, along with improvement in gait and function. No basis for this statement is present in the reviewed medical records. An authorization form, dated January 26, 2014, notes a 50% improvement, again from the second epidural.

AA. According to Respondent’s records, this patient was not seen again after the February 25, 2014, epidural injection.

BB. Respondent’s records provide no information about the course of her pain other than the occasional need for more injections or an increase in hydrocodone. There is no documentation of the response to opioids, any functional improvement, side effects or abuse. There is no documented attempt to monitor opioid usage, such as CURES reports, urine drug screens or pill counts. No rational is given for changes in opioid dosing. No rationale is given as to why procedures are done or how effective they are, other than one statement that they were effective three months ago. Epidurals appear to be done as a
routine “series of three,” with no explanation as to why or whether one or two injections might suffice. The only documentation as to the efficacy of the procedure comes from the notes of the HMO staff, who document phone conversations. It is opaque as to whom in Respondent’s office is speaking with the HMO or where they are getting the information as to functional improvement, as functional improvement is not documented in the chart.

It is not possible to tell why the patient carries the diagnosis of lumbar disc herniation. While there is a lumbar MRI in the chart, located there adjacent to her records from the later part of her course of treatment, there is no documentation that this MRI was ever seen.

CC. In short, it is impossible to tell, from Respondent’s records, why the patient was being treated and how she was responding to that treatment.

DD. The records are not complete. There is so little information in them that it is not possible to tell if they are accurate. There is no indication as to why the treatment plan was changed, whether with medications or injections. One is left to assume that medications were increased because of ongoing pain, but there is no documentation of improvement as a result of those changes. The closest the notes come to explaining why a procedure is needed is in the November 19, 2013, note which indicates that she had a good response to a previous epidural and she needs a repeat. One is left to assume that the previous epidural (actually, series of three), which provided an unknown amount of relief has worn off.

Patient A.M.

EE. Patient A.M.’s undated history indicates that she was seen because of bilateral knee pain. Because she was too young⁴ to have total knee replacements, she sought consultation with Respondent. She indicated that she had bilateral knee surgery or surgeries, including ACL repair. Her pain diagram shows cervical, bilateral upper extremity versus shoulder, elbow and wrist pain, along with bilateral knee pain. The form did not indicate that she was taking any analgesics, including OTC.

⁴ A.M. is 34 years of age.
FF. Patient A.M. signed a “pain contract” with Respondent. In the contract, however, there is no mention of opioid risks. The two page preprinted consultation form of August 19, 2013, merely indicated that the patient was being seen for knee pain. She was listed as being on Norco “10x6.” Respondent’s physical examination reported a moderate antalgic gait and no use of an assistive device. Patient A.M. was noted to have a “lax right knee, with [illegible] dislocation.” She was provided Norco 10/325 qid and Soma 350 mg qid. Soma is generally used as a muscle relaxant. It is unclear why a muscle relaxant was prescribed. There is no CURES report and no urine drug screen.

GG. Patient A.M. was next seen on September 23, 2013. The preprinted consultation form includes a line for “breakthrough pain,” rated between none and constant. Drug seeking behavior is rated as ½ way between none and profound, although there is no discussion as to why that rating was chosen or whether there should be any response to it. For reasons not provided, MS Contin 15 mg #60 was added to the Norco 10/325 #120 and the Soma 350 #120.

HH. On October 22, 2013, the patient’s medications were renewed. On November 19, 2013, the note states that the prescription (Rx) is illegible. The Soma is decreased to 3/day. Adjacent to the Soma decrease is an illegible handwritten comment.

II. On December 19, 2013, the Soma is increased to #4/day, the Norco maintained at #4/day and the MS Contin increased to #3/day. She was noted to have profound pain behaviors and situational depression. No rationale for the medication changes is provided. A rheumatology consult is requested, for reasons not provided. In his interview, Respondent indicated that he saw primarily HMO patients who were worked up and managed by their primary care physicians. In that setting, it is unclear why Respondent would obtain a rheumatology consult.

JJ. On January 16, 2014, Patient A.M.’s MS Contin was decreased to #60 and her Soma and Norco maintained. Again, no explanation for the change was provided.

KK. On February 6, 2014, the MS Contin was increased to #90. No explanation is provided as to why she is seen 21 days after her previous visit. On March 6, 2014, Patient
A.M.'s medications were maintained. No prescription is available for the April 3, 2014, visit; her medications were maintained on May 1, 2014, and again on May 29, 2014.

LL. The first typed note on May 29, 2014, discusses Patient A.M.'s diagnoses, comorbidities (obesity) and her medications, including adequate analgesia. No pain score is given. She is to have a neurology exam for headache. The physical exam is limited to gait and the use of assistive devices. She is noted to have "some degree of opioid tolerance and dependence due to previous medical management."

MM. On June 19, 2014, a CURES report is obtained. Patient A.M. received #15 Norco 5/325 from a Dr. P., on April 25, 2014. Otherwise, her opioids and Soma came only from Respondent while a Dr. D. provided alprazolam.

NN. A note, dated June 26, 2014, indicates that the CURES report is "ok." There is no discussion of what is likely an urgent care visit with a Dr. P. Respondent's documentation is improved but the Soma is decreased to #90 with no explanation as to why.

OO. A prescription, dated July 24, 2014, increases the Soma again to 90 and decreases the MS Contin to #60. The accompanying note mentions but does not explain the change. The patient's medications are maintained on August 21, 2014.

PP. One of the patient notes shows an undated consult from R.A., M.D., specialty not provided, indicating that the patient had been on Norco until "about six weeks ago" and was requesting a pain management consult for medication management. The accompanying request for the consult is dated May 3, 2013. Patient A.M.'s Walgreen's pharmacy records indicate that a Dr. D. provided Norco #3/day and Soma #3/day prior to the patient being seen by Respondent. Other than the one episode of getting #15 Norco from a Dr. P., the pharmacy records show no evidence of doctor shopping.

QQ. Respondent's history is essentially limited to the chief complaint and his exam limited to gait and the absence of an assisted device. There is no discussion of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled
substance. If the referring physician’s notes discuss any of these items, there is no indication in Respondent’s notes that he is aware of that discussion.

RR. The poor quality history and exam is an extreme departure from the standard of care.

SS. Respondent’s notes do not track outcomes. Medication doses are changed with no rational for the change. There is no discussion as to how her treatment plan is working. Respondent did not provide any meaningful or understandable criteria by which to determine whether his treatment was providing some benefit.

TT. The absence of any treatment plan or objectives is an extreme departure from the standard of care.

UU. Respondent provided no information regarding the patient’s progress. He did not monitor function in any meaningful way and did not monitor any other parameter which might be expected to change with opioid therapy. There is no explanation as to why therapies are changed. In many cases, there is no notation that they have changed. Doses are decreased and the next month increased with no explanation. There is no impression that the patient is being monitored.

VV. It is not possible to determine if the records are accurate because they are so minimalistic and contain little information upon which to judge accuracy. The records are not complete, lacking any meaningful past history, physical exam, discussion of the patient’s problems and rationale for the plan for treatment.

WW. Respondent’s failure to provide meaningful periodic review and maintaining records is an extreme departure from the standard of care.

XX. Soma is a muscle relaxant. In doses of greater than about 1000 mg/day (#3 Soma 350 mg), the blood levels of its metabolite meprobamate will equal those achieved after taking a Milltown, a common sedative prior to the advent of benzodiazepines. While the use of Soma is appropriate, there should be a medical reason for its use.

YY. Patient A.M. was on Soma prior to seeing Respondent. She was seeing him for knee pain. There is no identified muscle spasm. Accordingly, there is no rationale for the
use of Soma 350 mg tid. The mere fact that she had been on it previously was no rational for continuing the medication. This is particularly true where the provider has identified
“some degree of opioid tolerance and dependence due to previous medical management.”
If there are issues with the previous medical management, then the physician should clarify how his or her treatment regimen responds to those issues. Providing Soma in this instance does not meet this standard.

ZZ. The provision of Soma for a patient with osteoarthritis and knee pain is a simple departure from the standard of care.

Patient H.T.

AAA. H.T., then 47 years old, first presented to Respondent on March 15, 2012. Her undated intake form indicated that she was a hair stylist. She was taking Vicodin ES 4-
6/day and Soma 6/day along with ibuprofen 600 mg tid, Prilosec and Imitrex. She reported
neck and bilateral arm pain, along with low back pain. A cervical MRI, performed on
February 22, 2007, showed uncovertebral joint hypertrophy with disc/osteophyte
complexes with mild left C5-6 foraminal stenosis. A repeat cervical MRI, performed on
January 24, 2012, revealed right C4-5 foraminal stenosis, minimal bilateral C5-6 foraminal stenosis and a new C6-7 2-3 mm left lateral protrusion attenuating the left C7 lateral recess.
A Progress Note from a D.D., dated January 27, 2012, is essentially illegible but does note
neck pain.

BBB. Her initial consult of March 15, 2012, documents a 10 year history of neck and bilateral upper extremity pain. Previous therapies are described. A past medical history is present, as is reference to her cervical MRI. She was provided MS Contin 15 mg bid,
Vicodin 7.5 mg bid and Soma 350 mg tid. A cursory exam is documented. An assessment is made. She is described as having “some degree of opioid tolerance,” but no discussion is provided as to why that opinion is held or how the tolerance is to be responded to. The plan was for medications and a cervical epidural.

CCC. A “Medication Contract,” dated March 15, 2012, describes the terms under which medications will be provided, is present. No informed consent is present.
DDD. On April 3, 2012, Patient H.T. had a C6-7 epidural steroid injection. As is characteristic of Respondent's procedure notes, it is not possible from the information provided to determine where the site of service was. On the same date, he provided Vicodin 7.5 #60. A second cervical epidural was done on April 9, 2012, and a third on April 16, 2012. On April 16, 2012, she was provided Norco 7.5 #90 and Soma 350 #90. No rationale is given as to why what appears to be a month's supply of hydrocodone was given two weeks after a previous month's prescription.

EEE. Patient H.T. was seen for follow up on May 14, 2012. Her response to the injections were noted. Voice recognition technology was clearly used to write the note. Possible drug seeking behavior is identified but no discussion as to what that behavior was or what the response should be is provided. Her Soma and Norco prescriptions were refilled, as they were again on June 4, 2012. No explanation is provided as to why a patient with possible drug seeking behavior is given a month's refill on her medications 21 days into the month.

FFF. Patient H.T. was next seen on June 14, 2012. Her medications, injections and possible "mild opioid dependence" were noted. The plan was to taper. On July 12, 2012, her Soma was decreased to bid. Her other medications were maintained. Difficulties with voice recognition make the note difficult to decipher. On January 16, 2012, Respondent returned to his preprinted progress note, with an exam limited to gait and no mention of benefits or issues associated with opioid therapy. A note, date November 13, 2013, reads, "trial [illegible, perhaps HC]." She was continued on her meds, again with scanty documentation.

GGG. On April 23, 2013, there is a note for a cervical epidural steroid injection at C6-7. Again, a preprinted form is used with minimal detail site of service, type of monitoring if any, sedation if any or any information specific to this injection other than level of the injection, the fluoroscopy time or 80 mg of Depomedrol being used. Patient H.T. had a second epidural on April 30, 2013, and a third on May 7, 2013.
HHH. She was continued on her medications unchanged. A progress note, dated May 21, 2013, does not reference the injections. Patient H.T. continued to be treated medically, with Mobic and Zanaflex being added on July 15, 2013, with no indication as to why. These were maintained on August 12, 2013.

III. There is a notice of a police report, dated August 24, 2013, regarding Patient H.T.’s bag which contained her medications being stolen from her car.

JJJ. The note of August 29, 2013, does not reference the theft. Her medications were maintained on September 27, 2013 and October 22, 2013. A note, dated October 22, 2013, indicates that she had “good relief from the ESI last year, pain back.”

KKK. She had a C6-7 ESI on November 19, 2013, at which date she was also given Norco qid and Soma bid for 30 days. On November 26, 2013, she was given Percocet 10/325 #120 and Soma 350 #90; CESI #2 on November 26, 2013; and, CESI #3 on December 3, 2013. Documentation is unchanged.

LLL. On December 12, 2013, Patient H.T. was given Norco 10/325/#90. No rationale is given for the change in dose or medication. On January 9, 2014, the patient was given the same medications. On February 6, 2014, the Norco was increased to #120

MMM. On January 7, 2014, Patient H.T. had a lumbar MRI at the request of a E.B., M.D. It showed mild degenerative changes at L3-4.

NNN. Respondent’s note, dated February 6, 2014, referenced the MRI. He provided a lumbar ESI on March 6, 2014, at which time he also renewed the medications. The second ESI was done on March 18, 2014, at which time a request was made for physical therapy. The third ESI was done on March 25, 2014.

OOO. On April 10, 2014, as well as on May 6, 2014 and June 6, 2014, the Norco and Soma were maintained. A typed written note, dated June 6, 2014, contained more information than the preprinted forms. Again, there is the reference to opioid tolerance and dependence without a discussion as to what response, if any, should be made. The exam is limited to, as usual, gait and assistive device. There is no discussion as to the efficacy of
the medications. Voltaren had been added, again with no discussion as to why or whether it helped.

PPP. A note, dated July 1, 2014, indicates that a cervical epidural steroid injection was given. A second such injection was given on July 24, 2014 and a third on July 29, 2014, at which time Norco was refilled at #120. Patient H.T.’s last recorded visit was on August 26, 2014.

QQQ. Patient H.T.’s Walgreens pharmacy records show that a Dr. D. provided Norco 10/325 #45 on July 2, 2013, and on July 6, 2013. On September 8, 2013, a Dr. K. provided Percocet 5/325 #15. On November 22, 2013, Respondent provided Norco 10/325 #75. She obtained Percocet from a Dr. D. on October 8, 2012, and Vicodin from a Dr. B. on September 14, 2012. On September 12, 2012, she got Norco from a J.F. On October 30, 2012, she got Norco from Dr. D. On April 10, 2013, she got Percocet from Dr. D.

RRR. Respondent’s physical examination of Patient H.T. was overly cursory. A treatment plan was laid out, but no objectives were presented. While a pain contract is given, no informed consent is indicated.

SSS. Respondent changed medication with no explanation. There is monitoring of the effectiveness of therapy. There is no CURES or UDS. Walgreens records show multiple episodes of obtaining medications from other providers while she was getting opioids from Respondent.

TTT. Even without getting medications from other providers, there were two episodes, one on April 16, 2012, and the other on April 26, 2013, where Patient H.T. was given an early refill with no explanation. She was described as having possible drug seeking behavior, but there is no discussion as to what that behavior was or what the response should be.

UUU. Respondent did not perform a periodic review of Patient H.T.’s medications.
Patient O.S.

VVV. Patient O.S., a 56-year-old, was first seen on October 17, 2011. His undated intake form indicated a 5 month history of pain in the shoulder, elbows and left knee. He was unemployed and was taking Lortab daily. The initial consult describes him as a 56-year-old alcoholic with episodic pain due to gout. A focused exam is present. He was diagnosed as having degenerative joint disease, gout and chronic intractable pain. No linkage is provided between episodic pain due to gout and the need for daily opioids. He was provided Norco or Vicodin 7.5 bid on a roughly monthly basis. A medication contract was signed 3 months later, on February 2, 2012, but no opioid agreement was provided. As of February 2, 2012, his pain was described as coming from degenerative joint disease. Diclofenac 75 mg bid was added on January 5, 2012.

WWW. On May 25, 2012, a note indicates that Patient O.S. had good analgesia with this profile. On June 21, 2012, the note indicates “adequate analgesia and levels of activation.” On July 19, 2012, the gout diagnosis was dropped. On October 1, 2012, Respondent started using preprinted progress forms, with minimal documentation. On October 30, 2012, the diagnosis of post laminectomy syndrome was added. MS Contin was started, evidently to stop the acetaminophen because of the history of cirrhosis. Patient O.S. continued to be seen at roughly monthly intervals. On June 23, 2013, a note read to discontinue Voltaren due to renal issues. The source of information about the kidneys was not provided. Patient O.S. continued to be seen periodically.

XXX. On March 26, 2014, Respondent received a notice from United HealthCare indicating that the patient was prescribed tramadol #60 on February 1, 2014, from a T.P. and tramadol 50 mg #20 on February 28, 2014, from a Dr. N., along with 2 earlier prescriptions from a Dr. P., more tramadol from a Dr. S. and #6 Dilaudid 2 mg from another Dr. N. Respondent’s notes did not mention this letter. A CURES report, dated July 17, 2014, showed multiple episodes of other providers prescribing Norco and Dilaudid.

YYY. Respondent’s last record for Patient O.S. showed a plan to increase the MS Contin to tid.
ZZZ. Respondent’s records of his physical examination and medical history of Patient O.S. are sparse. As is apparently characteristic of Respondent’s examinations, the history and examination are scanty. This history and exam are set apart because the patient appeared to have changing diagnoses. The initial consult provides a chief complaint of chronic intractable pain due to gout; the final diagnoses are degenerative joint disease, gout and chronic intractable pain. Later, on October 30, 2012, the diagnosis of post lumbar laminectomy syndrome appears. There is no information in the initial history discussing the roles of pain from gout versus degenerative disease; there is no discussion in the progress notes to explain why the diagnosis has been changed to post lumbar laminectomy syndrome. The patient reported, in his initial intake, that his pain arose for no clear reason five months prior to the initial visit of October 17, 2011. The note does not define what type or kind of pain. Also, Respondent does not explain why opioids were being prescribed.

AAAA. The scant history and examination provided are an extreme departure of care.

BBBB. Respondent, again, did not monitor functional improvement or pain relief in any meaningful way. He also did not consult a CURES report until July 2014, when multiple episodes of provider overlap were seen. It was the standard of care during the period when Respondent was treating the patient to obtain CURES reports and UDS.

CCCC. The lack of monitoring of Patient O.S. was an extreme departure from the standard of care.

Patient B.C.

DDDD. Patient B.C., a 52-year-old, was first seen on May 7, 2013. Her intake form indicated that she had low back pain since having stepped into a manhole several years before. She was taking Percocet 10/325 every q 6 hours. The consult indicates that she had an ESI in the past with benefit and the examination is expanded to include a mention of a motor/sensory exam. She had ESIs on May 28, 2013 and June 4, 2013, when she was given Percocet. A pain agreement, but not an informed consent, was signed. The third ESI was
on July 2, 2013, when her Percocet was refilled. Respondent failed to record the patient’s
response to the injections. She was given refills for her medications on September 24,
2013.

EEEE. On November 19, 2013, her pain was noted to be increasing. Patient B.C. was
next seen on December 17, 2013. She received the first of three epidural injections on
January 14, 2014. The second was administered on February 11, 2014; the third on March
21, 2014.

FFFF. On April 16, 2014, Patient B.C. was noted to have had lumbar epidural steroid
injections. As of August 22, 2014, Respondent switched over to progress notes. The
epidural injection was noted to have given a 40% decrease in her pain. Her Percocet was
slowly weaned from 10 mg to 7.5 mg to 5 mg.

GGGG. On July 20, 2014, there was a UDS, which was negative for opiates and
oxycodone, but which was positive for methadone. Based upon the results of this UDS,
Respondent discharged her.

HHHH. A CURES report and a pharmacy report show multiple episodes of provider
overlap for opioid prescribing.

III. Respondent failed to monitor the effectiveness of opioids and failed to use a
CURES report.

JJJJ. Respondent’s care and treatment of Patient B.C. was a simple departure from
the standard of care.

**Patient C.C.**

KKKK. Patient C.C., a 43-year-old, was first seen on February 22, 2012. Her intake
form indicated pain all over her body with joint stiffness. She was diagnosed with lupus at
age 14. She was on Norco, tramadol and a muscle relaxer. The initial consult documents
her history and a focused exam is present. She was maintained on Flexeril 10 mg tid. In
addition, Diclofenac 75 mg bid was started. A medication contract, but no informed
consent, was signed by the patient.
LLL. She was next seen on March 28, 2012. There was no mention of the response to medication. MS Contin was added at night. She was seen periodically, on June 6, 2012, and June 26, 2012, without progress notes. The same occurred on October 3, 2012, October 31, 2012, and November 28, 2012, and continued at roughly monthly intervals. There is no discussion as to what she was doing for pain control in July and August 2012. On July 12, 2013, the note was to taper next month, although the reason why is not clear. On September 8, 2013, the plan was to get a lumbar MRI to rule out a disc protrusion. Her medications were periodically changed so that on November 22, 2013, she was on Percocet 10/325 qid. No explanation is given for the change. On the next visit, January 10, 2014, she was lowered to Percocet 7.5 qid, with no clear explanation for the change.

MMMM. Patient C.C. had lumbar epidural steroid injections on April 9 and 25, 2014. Respondent’s notes are unclear as to whether she received a third such injection on May 2, 2014.

NNNN. A CURES report, dated August 20, 2014, showed one episode of overlap on March 3, 2014, when she got #30 Percocet 10/325 from a Dr. Y.

OOOO. What appears to be a UDS request is present on September 16, 2014. However, the results are not in the records.5

PPPP. Rite Aid pharmacy records show Percocet 10/325 #15 from another doctor and #7 Norco from still another doctor on November 21, 2012.

QQQQ. While there are instances where the efficacy of the opioids is described, generally, there is no monitoring. The doses are changed for no clear reason. It is not clear where she was getting pain control during July and August 2012 or during December 2014. A CURES report was obtained, but not until 2014. A UDS was obtained but not until 2014.

RRRR. The quality of Respondent’s periodic review of his care and treatment of Patient C.C. is below the standard of care.

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5 This appears to be the patient’s final visit.
SECOND CAUSE FOR DISCIPLINE
(Prescribing to Addicts)

19. Respondent is subject to disciplinary action under Business and Professions Code section 2241, in that he prescribed controlled substances and other dangerous drugs to individuals he knew or should have known were addicts, as follows

   A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE
(Prescribing Without Medical Indication or Without Performing An Appropriate Prior Examination)

20. Respondent is subject to disciplinary action under Business and Professions Code section 2242 in that Respondent prescribed controlled substances and other dangerous drugs without medical indication and without performing an appropriate prior examinations, as follows:

   A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE
(Violation of Drug Statutes)

21. Respondent is subject to disciplinary action under Business and Professions Code section 2238, in connection with Business and Professions Code sections 725, 2241 and 2242, and Health and Safety Code sections 11152, 11153, and 11190, for violating applicable drug statutes, as follows:

   A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence)

22. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during his care, treatment and management of Patients M.K., L.A., A.M., H.T., B.C., C.C., and O.S., as follows:
A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

B. The following acts and omissions, considered individually and collectively, constitute extreme departures from the standard of care:

1) As to all patients, Respondent failed to review the course of pain treatment of the patients and any new information about the etiology of the pain or the patients' state of health on a regular basis.

2) As to all patients, Respondent failed to prepare treatment plans which listed objectives by which the treatment plan could be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned.

3) As to all patients, Respondent failed to keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.6

4) As to Patient M.K., failing to take an adequate medical history and perform an adequate physical examination.

5) As to Patient M.K., Respondent's treatment plan was to provide epidurals, opioids and NSAIDs. There is no documentation as to how this therapy should be evaluated. There is no documentation as to whether any of it was effective. There is no discussion of side effects. Patient M.K. died from complications of a gastrointestinal fistula. The role of the NSAIDS in developing that fistula is not known. The absence of

6 Pain levels, levels of function, and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver, and objective findings by the physician. Respondent's records are, for the most part, quick notes on a preprinted form. They do not constitute accurate and complete records and they do not provide a rationale for treatment plans or changes.
documentation of any side effects, at best, obscures any potential role the Voltaren may have had in her fistula.

**SIXTH CAUSE FOR DISCIPLINE**

(Repeate Negligent Acts)

23. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts during his care, treatment and management of Patients M.K., L.A., A.M., H.T., O.S., B.C., and C.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

B. The following acts and omissions constitute departures from the standard of care:

1) As to all patients, Respondent failed to review the course of pain treatment of the patients and any new information about the etiology of the pain or the patients' state of health on a regular basis.

2) As to all patients, Respondent failed to prepare treatment plans which listed objectives by which the treatment plans could be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned.

3) As to all patients, Respondent failed to keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

4) As to Patient M.K. failing to take an adequate medical history and perform an adequate physical examination.

5) As to Patient M.K., Respondent's treatment plan was to provide epidurals, opioids and NSAIDs. There is no documentation as to how this therapy should be evaluated. There is no documentation as to whether any of it was effective. There is no
discussion of side effects. Patient M.K. died from complications of a gastro cutaneous fistula. The role of the NSAIDS in developing that fistula is not known. The absence of documentation of any side effects, at best, obscures any potential role the Voltaren may have had in causing her fistula.

6) As to Patient M.K., failing to identify or follow any parameter of success of therapy.

7) As to all patients, overprescribing opioids.  

8) As to all patients, failing to conduct periodic reviews of patients’ progress.

SEVENTH CAUSE FOR DISCIPLINE
(Incompetence)

24. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), in that he lacks the education, skill, and knowledge to treat patients suffering from addiction and substance abuse, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 18, above, as though fully set forth.

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7 A physician and surgeon may provide opioids in order to provide increased function, as monitored by the parameter of the physician’s choice, while avoiding abuse or diversion. In this case, however, Respondent provided M.K. with a month’s supply of Percocet on March 25, 2013. On April 15, 2013, he provided another 30 tabs of Percocet. Even assuming arguendo that Respondent was increasing, but not documenting, the dose from bid to tid, he should have provided roughly a one week’s supply, as her original prescription would have run out in one week, rather than #30 tabs. Moreover, one week later, on April 22, 2013, Respondent prescribed another 90 tablets. This would amount to the renewal of the March 25, 2013 prescription, except for the additional tablets given one week before. On April 29, 2013, Respondent provided another 90 tablets without justification. There appears to be no mechanism by which he is aware of his previous prescribing.

8 Patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually in order to determine their response to treatment. Satisfactory response to treatment may be indicated by the patient’s decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient’s response to treatment.
EIGHTH CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate and Accurate Medical Records)

25. Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to prepare and maintain adequate and accurate medical records relating to the provision of his services to Patients M.K., L.A., A.M., H.T., O.S., B.C., and C.C., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 18 and 22, subparagraph (B)(3), above, as though fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 56468, issued to Philip James Morgan, M.D.;

2. Revoking, suspending or denying approval of Philip James Morgan, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Philip James Morgan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: October 22, 2015

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

Complainant

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MorganAccusationRevised.docx