In the Matter of the Accusation Against:

SHERIE CARNEGIE, D.O.
8142 Firestone Blvd.
Downey, CA 90241

Osteopathic Physician's and Surgeon's
Certificate No. 20A 6691,
Respondent

Case No. 900 2016 000590
OAH No. 202011004

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on 8/10/2020.

It is so ORDERED 7/27/2020.

CHERYL WILLIAMS, VICE PRESIDENT
FOR THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

SHERIE CARNEGIE, D.O.
8142 Firestone Blvd.
Downey, CA 90241

Osteopathic Physician's and Surgeon's
Certificate No. 20A 6691

Respondent.

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
entitled proceedings that the following matters are true:

PARTIES

1. e Mark M. Ito (Complainant) is the Executive Director of the Osteopathic Medical
Board of California (Board). He brought this action solely in his official capacity and is
represented in this matter by Xavier Becerra, Attorney General of the State of California, by
Wendy Widlus, Deputy Attorney General.

2. e Respondent Sherie Carnegie, D.O. (Respondent) is represented in this proceeding by
attorneys Richard A. Moss, Esq., whose address is: 255 South Marengo Avenue, Pasadena, CA
91101-2719, and Mark T. Roohk, Esq., whose address is: 255 S. Marengo Avenue, Pasadena, CA 91101-2719.

3.e On or about July 17, 1995, the Board issued Osteopathic Physician's and Surgeon's Certificate No. 20A 6691 to Sherie Carnegie, D.O. (Respondent). The Osteopathic Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 900-2016-000590, and will expire on April 30, 2022, unless renewed.

JURISDICTION

Accusation No. 900-2016-000590 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 20, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

4.e A copy of Accusation No. 900-2016-000590 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5.e Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 900-2016-000590. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6.e Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7.e Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation
9. e For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges in the Accusation, and Respondent hereby gives up her right to contest those charges.

10. e Respondent agrees that if she ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 900-2016-000590 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. e Respondent agrees that her Osteopathic Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. e This stipulation shall be subject to approval by the Osteopathic Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Osteopathic Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. e The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order shall have the same force and effect as the originals.

14. e In consideration of the foregoing admissions and stipulations, the parties agree that
the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

**IT IS HEREBY ORDERED** that Osteopathic Physician's and Surgeon's Certificate No. 20A 6691 issued to Respondent Sherie Carnegie, D.O. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1.0 **Obey All Laws.** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2.0 **Quarterly Reports.** Respondent shall submit to the Board quarterly declaration under penalty of perjury on the Quarterly Report of Compliance Form, OMB 10 (07/08) which is hereby incorporated by reference, stating whether there has been compliance with all the conditions of probation.

3.0 **Probation Surveillance Program.** Respondent shall comply with the Board's probation surveillance program. Respondent shall, at all times, keep the Board informed of her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Board. Under no circumstances shall a post office box serve as an address of record.

   Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4.0 **Interviews with Medical Consultants.** Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

5.0 **Cost Recovery.** The Respondent is hereby ordered to reimburse the Board the amount of $23,526.25 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and
prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship.

6.e **License Surrender.** Following the effective date of this decision, if Respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender her certificate to the Board. The Board reserves the right to evaluate the Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no longer be subject to the terms and conditions of probation.

7.e **Tolling for Out-of-State Practice or Residence, or In-State Non-Practice (Inactive License).** In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the board or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in Section 2051 and/or 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

8.e **Probation Violation/Completion of Probation.** If Respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving Respondent notice and the opportunity to be heard. If an Accusation and/or Petition to revoke is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final. Upon successful completion of probation, Respondent's certificate will be fully restored.

9.e **Clinical Training Program.** Within 90 days of the effective date of this
decision, Respondent shall submit to the Board for its prior approval, an intensive clinical training program. The exact number of hours and the specific content of the program shall be determined by the Board or its designee and shall be related to the violations charged in the accusation. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Board or its designee related to the program's contents.

10.o **Pharmacology Course.** Within 60 days of the effective date of this decision, Respondent shall enroll in PBI Prescribing Course: Opioids, Pain Management, and Addiction (RX-21) a course in Pharmacology, approved in advance by the Board or its designee, and shall successfully complete the course during the first year of probation.

11.o **Controlled Drugs - Partial Restriction.** Respondent shall not prescribe, administer, dispense, order, or possess any Schedule II and III controlled substances as defined by the California Uniform Controlled Substances Act except for ordering or possessing medications lawfully prescribed to Respondent for a bona fide illness or condition by another practitioner, until Respondent completes the Clinical Training Program and Pharmacology course and has been so notified by the Board in writing.

12.o **Controlled Drugs - Maintain Record.** Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by Respondent during probation, showing all the following: (1) the name and address of the patient, (2) the date, (3) the character and quantity of controlled substances involved and (4) the pathology and purpose for which the controlled substance was furnished. Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Board or its designee, upon request.

13.o **Reasonable Accommodation.** In light of various governmental orders and declarations of emergency prompted by the COVID-19 pandemic, Respondent may submit a written request to the Board, or the Board’s designee, for an extension of time or other reasonable accommodation to comply with this Order. The decision of whether to grant such a request shall be in the sole discretion of the Board or the Board’s designee.
ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Richard A. Moss, Esq. and Mark T. Roohk Esq. I understand the stipulation and the effect it will have on my Osteopathic Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Osteopathic Medical Board of California.

DATED: 6/15/20

SHERIE CARNEGIE, D.O.
Respondent

I have read and fully discussed with Respondent Sherie Carnegie, D.O. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/15/20

RICHARD A. MOSS, ESQ.
Attorney for Respondent

DATED: 6/15/20

MARK T. ROOHK, ESQ.
Attorney for Respondent
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Osteopathic Medical Board of California.

DATED: June 7, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

WENDY WIDLUSS
Deputy Attorney General
Attorneys for Complainant
Exhibit A

Accusation No. 900-2016-000590

PARTIES

1. e Mark M. Ito (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs.

2. e On or about July 17, 1995, the Osteopathic Medical Board of California (Board) issued Osteopathic Physician's and Surgeon's Certificate Number 20A 6691 to Sherie Carnegie, D.O. (Respondent). The Osteopathic 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 April 30, 2020, unless renewed.
JURISDICTION

3. This Accusation is brought before the Board under the authority of the following sections of the Osteopathic Act (Act) and of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3600 of the Code states:

The law governing licentiates of the Osteopathic Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine.

5. Section 3600-2 of the Code states:

The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California, however, persons who elect to practice using the term or suffix “M.D.” as provided in Section 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be subject to this section, and the Medical Board of California shall enforce the provisions of the article as to persons who make the election. After making the election, each person so electing shall apply for renewal of his or her certificate to the Medical Board of California, and the Medical Board of California shall issue renewal certificates in the same manner as other renewal certificates are issued by it.

STATUTORY PROVISIONS

6. Section 2450.1 of the Code states:

Protection of the public shall be the highest priority for the Osteopathic Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

7. Section 2227 of the Code states:

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

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

1 The Osteopathic Act is an initiative measure that was approved by the electorate on November 7, 1922. It appears in West’s annotated Business and Professions Code commencing at Section 3600, and in the appendix to the Deering’s Business and Professions Code, following Section 25762.
(2) Have his or her right to practice suspended for a period not to exceed one years upon order of the board.

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

(4) Be publicly reprimanded by the board.

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

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medicals 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.

8. Section 2234 of the Code states:

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

(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.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program.
described in Section 2052.5.

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

9. Section 2238 of the Code states:

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.

10. Section 4022 of the Code states:

“Dangerous drug” or “dangerous device” means any drug or device unsafe for self-use in humans or animals, and includes the following:

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

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

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

11. Section 2242 of the Code states:

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

(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 thee
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.

12.0 Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or admin-
istering 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 admin-
istering of drugs or treatment is guilty of a misdemeanor and shall be punished
by a fine of not less than one hundred dollars ($100) nor more than six hundred
dollars ($600), or by imprisonment for a term of not less than 60 days nor more than
180 days, or by both that fine and imprisonment.

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

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

COST RECOVERY

13.0 Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of
disciplinary proceeding before any board within the department or before the
Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
administrative law judge may direct a licentiate found to have committed a violation
or violations of the licensing act to pay a sum not to exceed the reasonable costs of
the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the
order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where
actual costs are not available, signed by the entity bringing the proceeding or its
designated representative shall be prima facie evidence of reasonable costs of
investigation and prosecution of the case. The costs shall include the amount of
investigative and enforcement costs up to the date of the hearing, including, but not
limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount
of reasonable costs of investigation and prosecution of the case when requested.
pursuant to subdivision (a). The finding of the administrative law judge with regard
to costs shall not be reviewable by the board to increase the cost award. The board
may reduce or eliminate the cost award, or remand to the administrative law judge if
the proposed decision fails to make a finding on costs requested pursuant to
subdivision (a).

(e) An order for recovery of costs is made and timely payment is not made as
directed in the board’s decision, the board may enforce the order for repayment in any
appropriate court. This right of enforcement shall be in addition to any other rights
the board may have as to any licentiate to pay costs.

(f) In any action for recovery of costs, proof of the board’s decision shall be
conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or
reinstate the license of any licentiate who has failed to pay all of the costs ordered
under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any
licentiate who demonstrates financial hardship and who enters into a formal
agreement with the board to reimburse the board within that one-year period for the
unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs
to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of
the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in
that board’s licensing act provides for recovery of costs in an administrative
disciplinary proceeding.

(k) Notwithstanding the provisions of this section, the Medical Board of
California shall not request nor obtain from a physician and surgeon, investigation
and prosecution costs for a disciplinary proceeding against the licentiate. The board
shall ensure that this subdivision is revenue neutral with regard to it and that any loss
of revenue or increase in costs resulting from this subdivision is offset by an increase
in the amount of the initial license fee and the biennial renewal fee, as provided in
subdivision (e) of Section 2435.

DEFINITIONS

14. Adderall is a Schedule II controlled substance as designated by Health and Safety
Code section 11055, subdivision (d)(1). It is a dangerous drug as defined in Business and
Professions Code section 4022. It has a high potential for abuse.

15. Alprazolam (known under the brand name “Xanax”) is a Schedule IV controlled
substance as designated by Health and Safety Code section 11057, subdivision (d)(1). It is a
dangerous drug as designated by Business and Professions Code section 4022. This
medication is used to treat anxiety and panic disorders.

16. Lorazepam (known under the brand name “Ativan”) is a Schedule IV controlled
substance as designated by Health and Safety Code section 11057, subdivision (d)(16). It is

a dangerous drug as designated by Business and Professions Code section 4022. The medication is used to treat anxiety disorders.

17.a Benzodiazepines are a class of psychoactive drugs primarily used to treat anxiety disorders, panic disorders, and anxiety caused by depression.

18.a Fluoxetine HCL (known under the brand name Prozac) is not classified as a controlled substance in the United States of America. The medication is a dangerous drug as designated by Business and Professions Code section 4022. The medication is a selective serotonin reuptake inhibitor used to treat depression.

19.a Carisoprodol (known under the brand name Soma) is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(17). It is a dangerous drug as defined in Business and Professions Code section 4022. Carisoprodol is a muscle relaxer that blocks pain sensations between the nerves and the brain. Carisoprodol should be used with caution in patients with CNS depression as it can exacerbate CNS depression. Carisoprodol may impair mental or physical abilities required for driving or operating machinery; carisoprodol-associated motor vehicle accidents have occurred in post-market experience. There may be an additive effect and an increase in CNS depression if carisoprodol is combined with ethanol or other CNS depressants. Caution must be used with simultaneous administration. Carisoprodol should also be used with caution in patients with a history of substance abuse or dependency.

20.a Diazepam (known under the brand name Valium) is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(9). It is a dangerous drug as defined in Business and Professions Code section 4022. It is a depressant drug.

21.a Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (e). It is a dangerous drug as defined in Business and Professions Code section 4022.

22.a Lyrica is the brand name for pregabalin, a Schedule V controlled substance as designated by Code of Federal Regulations title 21, 1308.15(1) and Health and Safety Code section 11058. It is a dangerous drug as defined in Business and Professions Code sections 4022. The medication is an antiepileptic medication indicated for the management of neuropathic pain associated with diabetic neuropathy, postherpetic neuralgia, fibromyalgia, and adjunct therapy in adults with partial onset seizures.

23.a Norco is a brand name for the combination of acetaminophen (a pain reliever that increases the effects of hydrocodone) and hydrocodone (an opioid pain medication.) It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in Business and Professions Code section 4022.

24.a Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

25.a A serotonin reuptake inhibitor (more commonly referred to by the acronym SSRIs) is a type of commonly prescribed drug for treating depression. SSRIs affect the chemicals that nerves in the brain use to send messages to one another. These chemical messengers, called neurotransmitters, are released by one nerve and taken up by other nerves. Neurotransmitters not taken up by other nerves are taken up by the same nerves that released them which is termed "reuptake." SSRIs work by inhibiting the reuptake of a
serotonin, an action which allows more serotonin to be available to be taken up by other nerves.

26.a Tramadol is a Schedule IV controlled substance as designated by the Code of Federal Regulations, title 21, section 1308.14(b)(3). It is a dangerous drug as defined in Business and Professions Code section 4022.a

27.a Trazadone is used to treat depression and is not classified as a controlled substance in the United States of America. A prescription is required to obtain the drug which has the potential for abuse. It is a dangerous drug as defined in Business and Professions Code section 4022.a

28.a Zolpidem, commonly referred to by the brand name Ambien, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32). It is a dangerous drug as designated by Code section 4022. Zolpidem is used to treat insomnia.a

29.a The National Institutes of Health's National Institute on Drug Abuse (NIDA) defines opioids as a class of drugs naturally found in the opium poppy plant. According to NIDA, some prescription opioids are made from the plant directly, and others are made by scientists in laboratories using the same chemical structure. Per NIDA, prescription opioids are often used as medicines to treat moderate to severe pain. Opioids can also make people feel very relaxed and "high" which is why they are sometimes used for non-medical reasons. Per NIDA, opioids can be highly addictive, and overdoses and death are common. Opioid drugs include synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others as well as heroin which is an illegal drug in the United States of America.a

30.a Cervicalgia is a general term used to describe neck pain. Neck pain is a symptom that can result from many different causes and treating neck pain is highly dependent on having an accurate diagnosis.a

31.a Polymyalgia rheumatica is defined as a disorder of the connective tissue characterized by pain and stiffness of the muscles. Polymyalgia rheumatica often occurs in association with temporal arteritis in which the arteries supplying blood to the head become inflamed or damaged. The cause of polymyalgia rheumatica is uncertain but is believed to be an autoimmune disease in which the body's own immune system attacks the connective tissues.a

32.a Myalgia describes muscle aches and pain, which can involve ligaments, tendons and fascia, the soft tissues that connect muscles, bones and organs. Injuries, trauma, overuse, tension, certain drugs and illnesses can all cause myalgia.a

33.a Myositis refers to any condition causing inflammation in muscles. Weakness, swelling, and pain are the most common myositis symptoms. Myositis causes include infection, injury, autoimmune conditions, and drug side effects. Treatment of myositis varies according to the cause.a

34.a CURES is the acronym for Controlled Substance Utilization Review and Evaluation System, a database of Schedule II, III and IV controlled substance prescriptions dispensed in California which serves the public health, regulatory oversight agencies, and law enforcement. Access to CURES is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care; and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes. In 2009 the California Department of Justice developed a searchable, online prescription drug monitoring program which made the CURES database available to registered health care providers, users, and a

(SHERIE CARNEGIE, D.O.) ACCUSATION
35. DIVA is the acronym for the first structured diagnostic instrument for proper diagnostic assessment of attention-deficit hyperactivity disorder (ADHD). DIVA is the successor of the earlier Semi-Structured Interview for ADHD in adults and is based on the DSM-IV criteria. DIVA asks about the presence of ADHD symptoms in adulthood as well as childhood, the chronicity of these symptoms, and significant impairments due to these symptoms. DIVA was developed in Dutch, and translated into many languages, because there was a need for a readily available, structured diagnostic instrument for proper diagnostic assessment of ADHD for clinical assessment purposes and in research.

36. Medication adherence, i.e. taking medications correctly, is generally defined as the extent to which patients take medication as prescribed by their doctors. This involves factors such as monitoring the patient's filling and refilling of prescriptions and pill counts, i.e. counting the number of pills that remain in the patient's medication bottles or vials.

37. PDMP is the acronym for prescription drug monitoring program, a state-based electronic database that tracks the prescribing and dispensing of controlled substances, such as the CURES Program. PDMP is a tool that can be used to address prescription drug diversion and abuse. PDMPs serve multiple functions, including patient care tool; a drug epidemic early warning system; and an investigative tool for drug diversion and insurance fraud.

**FIRST CAUSE FOR DISCIPLINE**

(Gross Negligence)

(Bus. & Prof. Code, § 2234, subd. (b))

38. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she committed acts or omissions involving gross negligence in the care and treatment of patients 1, 2, 3, 4, and 5. The circumstances are as follows:

39. Respondent is a Spanish-bilingual Family Medicine and primary care provider. Respondent is a member of the American Academy of Family Physicians and the American Osteopathic Association, and is certified by the American Board of Family Medicine.

40. Respondent is affiliated with the Presbyterian Intercommunity Hospital, the Downey Regional Medical Center, and the Lakewood Regional Medical Center.

41. On December 29, 2016, the Board received a complaint from the wife of patient 13 regarding Respondent’s treatment of her husband. The Board referred the matter to the Division of Investigation Investigations and Enforcement Unit (IEU) for investigation. IEU investigators

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2 The name of the patients and any witnesses are abbreviated to protect privacy rights. The names will be provided to Respondent upon written request for discovery.
obtained CURES reports for Respondent’s patients, conducted interviews of Respondent’s patients and/or family members, and obtained certified patient medical records from Respondent for five of Respondent’s patients.

41.e At the conclusion of the investigation a Family Medicine physician reviewed the patients’ records, and other materials obtained during the investigation as discussed in detail below.

**Patient 1**

42.e Patient 1 told the IEU investigator he originally injured his back at work while trying to move a drum of ink. Patient 1 found Respondent through his insurance provider’s website and was 33 years old when he first began treatment with Respondent.

43.e Patient 1 told the IEU investigator that he did not have any addiction problems prior to Respondent’s prescribing various medications to him. The IEU investigator asked Patient 1 why he took Adderall and Patient 1 explained he started to lose focus at work, was having a hard time concentrating and told Respondent about his concentration difficulty. In response Respondent had Patient 1 answer a questionnaire which she used to diagnose him with attention deficit disorder. Based on her diagnosis Respondent decided Patient 1 required Adderall to improve his focus and concentration.

44.e Respondent’s medical records for Patient 1 reflected notes for Patient 1 from January 7, 2014, to August 18, 2017.

45.e Respondent’s first medical record was dated January 7, 2014, and indicates that Patient 1 needed refills for Norco. Respondent’s note includes an examination of general appearance, cardiovascular and respiratory. Respondent refilled 150 tablets of Norco 10-325 mg at this visit.

46.e Respondent’s medical record dated May 2, 2014, includes a more thorough examination as part of an annual checkup conducted by Respondent’s Nurse Practitioner 1. In addition to general appearance, cardiovascular and respiratory, examinations of the head eyes, ears, nose, throat, neurologic system, extremities and musculoskeletal system are documented.

47.e Respondent’s medical record for July 11, 2014, reflects Nurse Practitioner 1 sawe
Patient 1 again and noted that Patient 1 was "considering stopping taking narcotics for pain [sic]."
Nurse Practitioner 1 refilled Patient 1’s prescription for opiate narcotics.

48. Respondent’s medical record for October 3, 2014, reveals Patient 1 saw Respondent and again expressed interest in being weaned off Norco. In response Respondent prescribed 120 tablets of Norco and 60 tablets of tramadol 50 mg to Patient 1. Respondent advised Patient 1 to "alternate tramadol to try to wean off Norco."

49. Respondent’s medical record for February 20, 2015, reflects Patient 1 was seen by Nurse Practitioner 2 who noted Patient 1 was unable to wean off of Norco. The medical record states Patient 1 had tried acupuncture, had been to the chiropractor, and was exercising every day. Nurse Practitioner 2 advised Patient 1 to stop taking the tramadol and continue to take the Norco. Nurse Practitioner 2 ordered an X-ray of Patient 1’s lumbar spine.

50. In Respondent’s medical record for May 5, 2015, Respondent noted that Patient 1 "changed to a warehouse job where he stands on forklift. He is in a new job that is easy but he gets distracted and. [sic].” At this visit Respondent diagnosed Patient 1 with attention deficit disorder without mention of hyperactivity. Patient 1 told the IEU investigator that at this visit Respondent prescribed Patient 1 two 30 day prescriptions of Adderall 20 mg for the current visit and the month after. A year and a half later in her medical record dated October 20, 2016, Respondent documented the utility of Adderall stating, “Adderall is working for him ... he has not made a mistake yet (at work).”

51. In Respondent’s medical record for April 20, 2017, Respondent noted Patient 1 “tried to stop Norco” again but the patient’s continued pain prevented him from doing so.

52. Respondent’s medical record for Patient 1’s final visit on August 18, 2017, reveal she continued to refill prescriptions for Norco for Patient 1 when she provided him with Norco prescriptions for “8/21, 9/21 and 10/21 [sic].”

Patient 2

53. The IEU investigator did not speak with Patient 2. According to Respondent’s medical record for Patient 2, the patient’s first clinic visit was February 5, 2014. Patient 2’s medical record state the patient was 49 years old with a history of chronic low back pain, sciatica.
and fibromyalgia when Respondent began to treat her.

54. a CURES reports and the medical documentation show Respondent prescribed approximately 120 tablets of Norco 10 mg a month from October 13, 2014, through February 10, 2015, for Patient 2.

55. a CURES reports and Respondent’s medical record for October 29, 2015, showa Respondent increased Patient 2’s Norco to 150 tablets a month. Respondent prescribed the increased quantity of Norco from October 29, 2015 through August 30, 2017.

56. a CURES reports and Respondent’s medical records show Respondent prescribed Lorazepam 2 mg at a quantity of 90 every few months.

57. a Respondent’s documentation in her medical record indicates that controlling Patienta 2’s pain was challenging. Notwithstanding Patient 2’s eventually taking 180 tablets of Norco 10 mg a month the patient continued to complain of significant pain.

58. a Multiple notes in Respondent’s medical records indicated Patient 2 suffered from considerable back pain. On March 21, 2014, Respondent’s medical record reflect that Patient 2 was suffering severe back pain. Eight months later on October 24, 2014, Patient 2’s medical records state “back is killing her [sic].”

59. a Patient 2 requested Respondent provide her with documentation to excuse the patienta from work due to her severe, continuing back pain. Respondent agreed and as a result, Patient 2 was excused from work for almost three months from October 24, 2014 through January 13, 2015.

60. a Respondent’s medical record for March 4, 2015, states that Patient 2 has to use aa wheelchair at work.

61. a Respondent’s medical record for December 1, 2015, reveals that Patient 2 was referred to gastroenterology because she was in “so much pain she has been screaming in br at work [sic].”

62. a Respondent’s medical record for April 18, 2017, states that Patient 2 presented toa Respondent for follow up for an abscess on her head. Respondent’s medical record states “she has pain all over her body, joints, legs, arms, sometimes she does not get out of bed [sic].”
Respondent suggested Patient 2 should start taking Lyrica and ordered rheumatologic screening laboratory tests to look into Patient 2’s complaints.

63.e Respondent’s medical record for May 10, 2017, states that Patient 2 was taking prednisone for a diagnosis of polymyalgia rheumatica. The record notes that Patient 2’s leg pain resolved and her shoulder was improving.

Patient 3

64.e The IEU investigator did not speak with Patient 3. Respondent’s medical record for Patient 3’s first medical visit on April 7, 2014, shows that Patient 3 was 64 years old. Respondent documented a diagnosis of “combinations of opioid type drug with any other drug dependence, unspecified abuse” as “under control, meds needed for myalgia, depression & anxiety”. [sic].”

65.e During Patient 3’s first visit Respondent refilled 120 tablets of carisoprodol 350mg and 180 tablets of Norco 10 mg for “unspecified myalgia and myositis” and refilled a prescription of 120 tablets of lorazepam 2 mg as a treatment for anxiety. During this visit Respondent also prescribed 300 mg of etrazodone a night to treat Patient 3’s insomnia.

66.e Patient 3’s husband died in 2014, and Respondent refers to the loss of Patient 3’s husband and documents in some of Patient 3’s medical records that the patient was grieving. Respondent’s medical record for May 5, 2017, states Patient 3 was grieving and “under a lot of stress with other family members” [sic].”

67.e Respondent’s August 12, 2014, medical record states Soma “helps her leg spasms” and further states that Soma and Norco were used to treat sciatica.

68.e Respondent’s February 6, 2015, medical records states when Patient 3 was seen “here neck hurts a lot” and that Patient 3 experienced considerable neck pain.

69.e Respondent’s August 31, 2015, medical record states, “she is taking it day by day [sic].”

70.e CURES reports and Patient 3’s medical records show Respondent continued to refill carisoprodol, lorazepam and Norco monthly from October 3, 2014, through August 14, 2015.

71. The CURES reports from September 11, 2015, through September 17, 2017, show
Respondent was no longer prescribing carisoprodol for Patient 3. It is unclear from Respondent’s medical records why Respondent stopped prescribing carisoprodol. Approximately six months after discontinuing the carisoprodol Respondent’s February 19, 2016, medical record states under the diagnosis category that Soma was stopped per “other psychoactive substance dependence, uncomplicated [sic].” Despite discontinuing the carisoprodol Respondent continued to prescribe monthly refills of Norco and Lorazepam for Patient 3.

Patient 3 still reported suffering pain despite Respondent’s monthly refills of 180 tablets of Norco 10 mg. Respondent’s February 19, 2016, medical record states Respondent reported that Patient 3 “still has sciatic pain, back pain, and bilateral knee pain.”

Respondent’s medical record dated August 4, 2016, states that Patient 3 “reports continued pain from fibromyalgia. Reports it is a little worse right now than it has been in the past. Also reports numbness in her toes and pain on the bottom of her foot. Also reports chronic neck pain [sic].”

Respondent’s medical record dated November 4, 2016, states Patient 3 complained “all body is hurting. Taking (Norco) and it’s helping, (a lot) [sic].”

Respondent’s medical record dated January 3, 2017, reports that “the pain is really bad [sic].”

Respondent’s medical record dated November 7, 2017, reports that Patient 3 stated she continued to be in pain but that Norco helped her with the pain.

Respondent’s final medical record was dated January 3, 2018, and was written by Nurse Practitioner 3 who noted that Patient 3’s drug screen performed three months previously on November 7, 2017, was positive for hydrocodone, hydromorphone and norhydrocodone.

Patient 4

The IEU investigator did not speak with Patient 4. According to Respondent’s medical records the patient’s first clinic visit was April 28, 2014, and it states the patient was 49 years old. Respondent documented that Patient 4 took Norco 10 mg every 4 to 6 hours in addition to Percocet 5 mg every 12 hours. During the visit Respondent’s medical record states she treated Patient 4’s insomnia with trazodone 150 mg in addition to 20 mg of Ambien a night.
79.e CURES reports and the medical records disclose Respondent was managing Patiente
4’s pain by providing Patient 4 with monthly refills of 60 tablets of Percocet 5 mg and 180 tablets
of Norco 10 mg.

80.e From October 3, 2014, through September 28, 2015, Respondent’s physician
colleague and Nurse Practitioner 4 provided refills of Percocet to Patient 4.

81.e From October 27, 2014, through September 1, 2015, Respondent’s physician
colleague and Nurse Practitioner 4 provided monthly refills of Norco.

82.e From October 27, 2014 through September 28, 2015, Respondent’s physician
colleague and Nurse Practitioner 4 provided prescriptions of Carisoprodol 350 mg, quantity of
120 to Patient 4.

83.e From October 26, 2015 through August 7, 2017, Respondent and her collegues
refilled Patient 4’s prescriptions for Carisoprodol 350 mg, quantity of 120.

84.e From January 19, 2016, through March 14, 2016, Respondent provided Patient 4 with the
three prescriptions for Percocet.

85.e Patient 4 continued to complain of persistent pain despite being on carisoprodol and
multiple different opiate narcotics. Respondent’s medical record dated April 28, 2014,
documented that “she cont[inues] to have a lot of pain. She is getting cortisone injections with
[Dr 1] and is paying 700 for injections”.

86.e Respondent’s medical record dated July 28, 2014, stated that Patient 4 was “havinge
pain all the time in her neck and left arm, but that isn’t anything new”[sic].” At this visit,
Respondent diagnosed Patient 4 with “anxiety state, unspecified” and prescribed alprazolam 0.25
mg one tablet three times a day. Respondent’s medical record indicates that she prescribed
Patient 4 90 tablets of alprazolam 0.25 mg with three refills.

87.e Respondent’s medical record dated February 24, 2015, states that Patient 4’s alprazolam
prescription was reduced from 0.25 mg three times a day to 0.25 mg once a day.

88.e Respondent’s medical record dated October 12, 2015, states that Patient 4 expresseded
interest in reassessing her medications. Respondent noted, “she is careful with harms and side
effects of taking excess. Pt has not gone to rheumatologist for a while and says she would like to
do so. The oxy is strong, and makes her brain go a hundred miles per hr. the Norco helps but m. [sic].” Respondent refilled Patient 4’s prescriptions for Norco and Soma and advised Patient 4 to stop taking the Percocet.

89.s Respondent’s medical record dated January 18, 2016, stated that Patient 4’s “pain is 10/10 constant. She goes to work as a groomer and is stuck in bed after from the pain. Was seeing pain management but is not any more because they changed her Rx to maximum of 2 pain pills per day. She would like to use the oxycodone again to help manage the pain. Still has pain, had an MRI about a year ago from pain management doctor. Says that the discs are Compressing. Is feeling more anxious as of late, with a hollow feeling in her stomach and sweaty palms. Has been on Xanax before but got off it”.[sic].” Respondent responded to this information by prescribing 90 tablets of 1 mg Xanax to Patient 4. Respondent treated Patient 4’s cervicalgia with a refill of Soma to be taken four times daily, Norco to be taken every 4 to 6 hours and restarted Percocet 5 mg taken twice a day.

90.s Respondent’s medical record dated April 12, 2016, noted that Patient 4 was “not happy with the Percocet. She thinks it is interfering with her thought patterns and makes her mind race”.[sic].” Respondent discontinued the Percocet and initiated treatment with tramadol 50 mg to be taken every 6 hours together with both the Norco and the Soma.

91.s CURES reports from April 29, 2016, to August 27, 2017, reveal Respondent and her colleagues prescribed 120 tablets of Tramadol 50 mg to Patient 4 every two months

92.s Respondent’s medical record dated September 28, 2016, states Patient 4 was managing her pain well with the medications given but is “hoping to get off the medication soon”.[sic].” During this visit Respondent provided Patient 4 with refill prescriptions for tramadol, Soma, hydrocodone, zolpidem, and Xanax.

93.s Respondent’s medical record dated December 21, 2016, documented that “she is stills in a lot of pain. She is trying to get by on what she is on”.[sic].” Respondent again provided the patient with refill prescriptions for tramadol, Soma, hydrocodone, zolpidem, and Xanax.

94.s Less than a month later Respondent’s medical record dated January 18, 2017, suggests Patient 4’s pain was uncontrolled when she wrote that the patient “barely getting
by".[sic]." Respondent medical record states she “suggested referral to pain mgmt. but she is reluctant”. [sic]."

95.e Respondent again documented Patient 4’s persistent pain in Respondent’s medical record dated June 9, 2017, which stated, “there are times when she feels that she needs stronger pain meds”. [sic]."

96.e Respondent’s medical record dated September 1, 2017, by Nurse Practitioner 3 stated Patient 4 had been taking pain medications for years and that Norco, Soma, and tramadol provided pain relief.

97.e Respondent’s medical record dated March 12, 2018, noted Respondent’s referral to pain management again, “53 y/o female patient is doing a little better in terms of her pain, she is having a rough time weaning herself down. She is using cbd and would like suboxone and no pain meds. The cbd helped with the neck and radicular pain”. [sic].”

**Patient 5**

98.e The IEU investigator did not speak with Patient 5. According to Respondent’s December 26, 2013, medical records for the patient’s first clinic visit, Patient 5 was 35 years old and suffered from severe lower back pain. Respondent examined Patient 5 and found periumbar tenderness. At this visit Respondent provided Patient 5 with prescriptions for 120 Norco 10 mg and Soma 350 mg. Respondent further noted Patient 5 had anxiety and refilled his prescription for 60 Valium 10 mg.

99.e Respondent’s subsequent medical records for the patient show that he was evaluated and treated by podiatry after complaining about foot and ankle pain. Respondent’s medical records for March 11, 2016, reflect that an X-ray of the patient’s cervical spine showed straightening and scoliosis probably related to muscle spasm but no acute bony abnormalities.

100. Respondent’s medical record for November 5, 2014, contains a more thorough history of Patient 5’s back pain, noting it began in 2004 and that the patient had tried a number of modalities including spinal decompression, epidural injections, and use of an inversion table daily prior to sleep to relieve the pain.

101. Respondent’s medical record for November 5, 2014, reflects the patient stated that...
taking three to four Norco a day allowed him to “get through the day but does not take the pain
away”. [sic].” At this visit Respondent refilled the patient’s Norco prescription with a quantity of
120 tablets and increased the dosage of Xanax from 1 mg to 2 mg.

102. Respondent’s medical record for November 5, 2014, also documented a discussion
with the patient regarding Patient 5’s sleep difficulties. Respondent’s medical record reflects the
patient disclosed he had been on Xanax, Ambien and Valium in the past and that “they work but
he has built up tolerance so they are no longer working”. [sic].”

103. Respondent’s medical record for January 13, 2015, reflects Patient 5’s continued
complaints of difficulty sleeping to Nurse Practitioner 2 who provided him with Ambien 5 mg at
this visit.

104. Respondent’s medical record for March 11, 2015, reveals Patient 5 stated he ran out
of Ambien early because he was taking 10 mg instead of the prescribed 5 mg dosage. Nurse
Practitioner 2 responded by increasing the dose of Ambien to 10 mg. During this visit Nurse
Practitioner 2 advised the patient to discontinue the stop Xanax 2 mg and to instead take Prozac
40 mg a day to treat his anxiety.

105. Respondent’s medical record for September 18, 2015, states that Patient 5 toldt
Respondent he wanted to be put back on Xanax 2 mg twice a day. Respondent refilled his Xanax
2 mg prescription along with refills of Norco, Soma and Ambien.

106. Respondent’s medical record for January 4, 2016, notes Patient 5 sustained a fall on
December 23, 2015, resulting in neck pain for which he was referred to a chiropractor and was
removed from work until February 15, 2016.

107. Respondent’s medical record for February 8, 2016, notes Patient 5’s neck pain was
not improving and that he requested more time off work. Respondent placed him off work until
March 15, 2016, and noted that an “American Fidelity disability [form] was filled out” by
Respondent. Respondent suggested physical therapy to Patient 5 who stated he did not have a
ride to go to physical therapy. Respondent refilled his prescriptions for Norco and Soma.

108. Respondent’s medical record for March 10, 2016, notes Patient 5 continued to
experience neck pain and that he requested Respondent to authorize more time off of work.
Respondent gave him time off until April 4, 2016. However, Respondent noted, “I have explained to him that I will not extend his disability until he starts PT. He is being given several options for PT, but will check with his insurance to see who is contracted. He is to call me when he starts PT, so we can verify and fill out disability form or will not be extended”. [sic].”

109. Respondent’s medical records reflect that on March 16, 2016, Patient 5 called Respondent’s office and stated he had started physical therapy.

110. Respondent’s medical record for March 31, 2016, stated that Patient 5 was feeling better since going to physical therapy but was still complaining of headaches which Patient 5 said were helped with hydrocodone. Patient 5 continued to attend physical therapy and his neck pain began to improve. Respondent extended Patient 5’s disability and time off until May 16, 2016.

111.a Respondent’s medical record for May 25, 2016, noted that “he feels confident he can perform his duties [at work without] limitations” and Respondent gave Patient 5 clearance to return to work on May 27, 2016, with no restrictions.

112. Respondent’s medical record for August 23, 2016, states Patient 5 continued to have worsening neck pain stemming from his injury in December 2015. Patient 5 “refused” to undergo the MRI Respondent suggested. Patient 5 stated Xanax made him sleepy and he wanted to take Valium instead as it helps his anxiety the best. Respondent did document a discussion with Patient 5 of the risks and benefits of using benzodiazepines like Valium. Per Respondent’s records the patient stated that “he feels he won't have an issue with addiction because he has had the same valium [sic] rx for over 2 years and has not abused it”. [sic].” Respondent accordingly prescribed 60 tablets of Valium 5 mg and refilled the patient’s prescriptions for Soma, Norco and Ambien.

113. Respondent’s medical record for December 16, 2016, reflects that Nurse Practitioner 3 noted Patient 5 continued to have worsening pain due to the cold weather. Nurse Practitioner 3 increased the patient’s dosage of diazepam from 5 mg to 10 mg.

114.a A March 14, 2017, note reflects Respondent discontinued the Patient 5’s diazepama prescription.

115. Respondent’s medical record for October 24, 2017, states that Patient 5’s urine drug
screen was negative for opiates. Respondent’s asserts “he states he had been out. If tests neg
next time can not get it here anymore, will need pain mgmt.”[sic].”

116.a Respondent’s medical record for February 9, 2018, indicates Patient 5 was in a cara
accident on February 6, 2018.a Patient 5 complained of constant neck pain. The record reflects
Patient 5 had neck pain for the past four months. Patient 5 inquired about receiving an MRI for
his neck. Patient 5 also requested a refill of Xanax for anxiety. In response Respondent noted
that Patient 5 “hasn’t taken norcos for 2 weeks and soma x 1 week. Pt needs to come in the next
Refilled for 2/9/19.” Respondent prescribed 30 tablets of Xanax 0.5 mg, 120 tablets of Norco and
120 tablets of Soma.

117.a Per Respondent’s medical records Patient 5 had an MRI February 15, 2018, whicha
showed mild broad based disc bulge at C3-C4, mild disc herniation noted at CS-6, disc herniation
was also noted at C6-C7 causing moderate to severe foraminal narrowing, central disc protrusion
was noted at C7-T1 resulting in moderate foraminal narrowing with no significant osteoarthritic
changes.

118.a Respondent’s medical record for July 25, 2018, reflects Patient 5 saw Nursea
Practitioner 3 who reduced the quantity of Norco and Soma to 90 tablets.

119. Respondent’s medical record for January 2, 2019, reflects Patient 5 saw Nurse
Practitioner 3 who advised him to stop taking the Soma. Nurse Practitioner 3 noted that the
patient was “viciously attacked and strangled by his wife. They are going through a divorce. Has
full custody 3-year-old. Taking care of him, bathing and changing him flares up his back pain.”

120. Respondent’s medical record for March 26, 2019, reflects Patient 5 returned to see
Respondent and requested refills of his medications for management of chronic neck and back
pain which had worsened due to the change of weather. Respondent ordered a urine drug screen.
Respondent refilled Patient 5’s Norco at a quantity of 90 tablets. Respondent discontinued
Patient 5’s Xanax prescription and noted a diagnosis of opioid dependence, uncomplicated.

STANDARD OF CARE

121. The standard of care in the community regarding informed consent is that the
Physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

122.s The standard of care in the community requires the physician to routinely 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.

123.s The standard of care in the community requires the physician to institute periodic review of a patient's pain treatment to determine if the patient's regimen of opiate narcotics should be continued or adjusted.

124.s The standard of care in the community with regard to the periodic review of a patient's ongoing pain management requires the physician to assess the appropriateness of continuing opiate narcotics and the consideration of the use of other therapeutic modalities if the patient's progress is unsatisfactory.

125.s The standard of care in the community requires the physician to consider referral of a patient as necessary for additional consultation for the evaluation and treatment of the patient's condition in order to achieve treatment objectives.

126.s The standard of care in the community requires the physician to consider referral of a patient with complex pain problems for consultation with a pain management specialist.

127.s The standard of care in the community requires the physician to give special attention to those pain patients who are at risk for misusing their medications such as those patients whose living arrangements pose a risk for medication misuse or diversion.

128.s The standard of care in the community for a physician prescribing opioid narcotics for non-cancer pain requires the physician to practice compliance monitoring. Physicians do so by checking a patient's conformity to the directions provided for taking a particular medication. Adherence to the standard of care requires the physician to review the patient's CURES/PDMP report, test the patient's urine for use of the drug and pill counting.

129.s The standard of care in the community for a physician prescribing opioid narcotics requires the physician to wean a patient off opiate narcotics if the physician believes the patient is addicted to them.
130.s The standard of care in the community for a physician who makes a diagnosis of adult ADHD requires the physician to perform in depth testing of the patient with a diagnostic interview of the patient which includes the use of the DIVA 2.0 diagnostic Interview.

131. The standard of care in the community requires a physician to limit the use of opiate narcotics, carisoprodol and benzodiazepines. It is not the standard of care to provide all three at once given the increased risk of respiratory depression and death.

132.s The standard of care in the community requires a physician to avoid long term use of benzodiazepines for the treatment of insomnia and anxiety. The standard of care in the community for a physician who is treating a patient for insomnia and anxiety requires the physician to consider the use of psychotherapy or serotonin reuptake inhibitors in lieu of the daily use of benzodiazepines.

**Departures from the Standard of Care**

133. Respondent demonstrated an extreme departure from the standard of care in her cares and treatment of Patient 1 when she failed to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

134. There is no documentation or pain contract in Respondent's medical records indicating that Patient 1 was aware of the risks and benefits of the use of controlled substances for the treatment of his chronic pain.s

135.s Respondent demonstrated an extreme departure from the standard of care in her cares and treatment of Patient 2 when she failed to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

136. There is no documentation or pain contract in Respondent's medical recordss indicating that Patient 2 was aware of the risks and benefits of the use of controlled substances for the treatment of her chronic pain.

137. Respondent demonstrated an extreme departure from the standard of care in her cares and treatment of Patient 3 when she failed to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

138.s There is no documentation or pain contract in Respondent’s medical recordss
indicating that Patient 3 was aware of the risks and benefits of the use of controlled substances for the treatment of her chronic pain.

139. o Respondent demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when she failed to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

140. o There is no documentation or pain contract in Respondent’s medical recordso indicating that Patient 4 was aware of the risks and benefits of the use of controlled substances for the treatment of her chronic pain.

141. o Respondent demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she failed to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient.

142. o There is no documentation or pain contract in Respondent’s medical recordso indicating that Patient 5 was aware of the risks and benefits of the use of controlled substances for the treatment of his chronic pain.

143. o Respondent demonstrated an extreme departure from the standard of care in her care and treatment of Patient 1 when she failed to routinely review (1) the course of pain treatment of the patient and (2) any new information about the etiology of the pain or the patient’s state of health.

144. o Respondent’s October 2, 2014, medical record reflects an extreme departure from the standard of care in her care and treatment of Patient 1 when they reveal she failed to appropriately review her treatment of Patient 1’s pain, continued to prescribe Norco and added another narcotic (tramadol) to treat the patient.

145. o Respondent’s October 2, 2014, medical records demonstrate an extreme departure when she failed to order physical therapy or any alternate modality to treat the patient’s shoulder pain.

146. o Respondent’s medical records demonstrate an extreme departure from the standard of care when she failed to order lumbar imaging to assess Patient 1’s persistent back pain.

147. o Respondent’s medical records demonstrate an extreme departure from the standard of care.
care when she failed to review the patient’s record to determine if there were results for a lumbar X-ray possibly performed after Nurse Practitioner 2 ordered the test in 2015.

148.a Respondent’s April 20, 2017, medical records demonstrate an extreme departure from the standard of care when she failed to reassess the effectiveness of the narcotic pain medication she continued to prescribe to Patient 1 on a monthly basis after he told her he tried and failed to stop using Norco.

149.a Respondent’s May 5, 2015, medical records demonstrate an extreme departure from the standard of care when she failed to appropriately review the cause and treatment of Patient 1’s complaint of becoming distracted at work.

150.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 2 when she failed to routinely review (1) the course of pain treatment of the patient and (2) any new information about the etiology of the pain or the patient’s state of health.

151.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 2 when she inappropriately increased the quantity of the patient’s pain medication after the patient’s pain increased despite utilizing physical therapy.

152.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 2 when she inappropriately utilized opiate pain medications after the patient’s pain increased requiring the use of a wheelchair while at work.

153.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 2 when she inappropriately utilized opiate pain medications after the patient’s pain increased to the point she was screaming from pain while at work.

154.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 3 when the patient continued to suffer from pain despite Respondent prescribing daily doses of opiates as high as 180 tablets of Norco a month.

155.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 3 when Respondent failed to consider other treatment
modalities for the patient.

156.e Respondent's medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when the majority of the patient's records note that her pain was not well controlled.

157. Respondent's medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when the majority of the patient's records note that her pain was not well controlled and Respondent continued nonetheless to recommend and prescribe daily use of opiate narcotics, benzodiazepines, zolpidem and carisoprodol.

158.e Respondent's medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when Respondent continued to recommend and prescribe daily use of opiate narcotics, benzodiazepines, zolpidem and carisoprodol and failed to refer Patient 4 to a pain management specialist.

159.e Respondent's medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when Respondent continued to treat the patient with daily use of opiate narcotics, benzodiazepines, zolpidem and carisoprodol despite the patient's communicated interest in discontinuing these medications.

160.e Respondent's medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she failed to reassess the value of the medications she chose to treat Patient 5's persistent back and neck pains.

161.e Respondent's October 24, 2017, medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when Respondent failed to reevaluate the treatment when she noted that Patient 5 had tested negative for opiates because he had run out of these medications. Although Respondent's notes indicate that she recognized the negative urine test as a red flag she refilled the prescriptions for opiate narcotics and carisoprodol instead of reevaluating her treatment options for Patient 5.

162. Respondent's February 9, 2018, medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she refilled his prescriptions for 120 tablets each. Respondent noted that Patient 5 had been in a car accident which resulted in

(SHERIE CARNEGIE, D.O.) ACCUSATION
constant neck and back pain. Despite his pain Patient 5 had managed not to take Norco for two
weeks nor Soma for one week. Respondent should have limited the quantity of the refills of the
medications rather than refilling the prescriptions for 120 tablets of each medication.

163.a Respondent’s medical records demonstrated an extreme departure from the standard
of care in her care and treatment of Patient 1 when she failed to direct the patient to specialists to
evaluate and treat the patient’s unremitting back pain which he had endured for approximately
eight years.

164.a In light of Patient 1’s ceaseless back pain and repeated, unsuccessful attempts to stop
taking opiates to relieve his pain, Respondent’s medical records demonstrated an extreme
departure from the standard of care in her care and treatment of Patient 1 when she failed to a
recognize her prescription of narcotics might cause him to become addicted to the medicationsa
she continued to prescribe for him.

165.a Respondent’s medical records demonstrated an extreme departure from the standard
of care in her care and treatment of Patient 3 when she failed to direct the patient to a specialist
for further evaluation and management of the patient’s anxiety.

166.a Respondent’s medical records demonstrated an extreme departure from the standarda
of care in her care and treatment of Patient 3 when she failed to direct the patient to obtain
physical therapy for treatment of her pain.

167.a Respondent’s medical records demonstrated an extreme departure from the standarda
of care in her care and treatment of Patient 3 when she failed to direct the patient to a pain
management specialist to evaluate and treat the patient for the patient’s persistent pain.

168. Respondent’s medical records demonstrated an extreme departure from the standard
of care in her care and treatment of Patient 5 when she, after he fell in December, 2015, continued
to extend his time off and disability despite the patient’s failure to present for ordered physical
therapy until April, 2016.

169.a Respondent’s medical records demonstrated an extreme departure from the standarda
of care in her care and treatment of Patient 5 when she failed to refer the patient to a pain
management specialist for his longstanding back and neck pain.
170. Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she failed to refer the patient to psychiatry for evaluation and treatment of his persistent anxiety.

171.a Respondent’s October 24, 2017, medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she failed to take prompt action when the patient had a negative urine screen.

172.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she failed to recognize Patient 5 had become addicted to opiate narcotics.

173.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she did not utilize appropriate testing to determine if Patient 5 suffered from adult ADHD.

174.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 3 when she prescribed opiate narcotics, carisoprodol and benzodiazepines at the same time for the patient given the increased risk of respiratory depression and death which can occur as a result of doing so.

175.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 4 when she prescribed opiate narcotics, carisoprodol and benzodiazepines at the same time for the patient given the increased risk of respiratory depression and death which can occur as a result of doing so.

176.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 5 when she prescribed opiate narcotics, carisoprodol and benzodiazepines at the same time for the patient given the increased risk of respiratory depression and death which can occur as a result of doing so.

177.a Respondent’s medical records demonstrated an extreme departure from the standard of care in her care and treatment of Patient 3 when she prescribed both regular refills of 150 mg of trazodone and regular monthly refills of high dose 2 mg lorazepam to treat the patient’s insomnia as doing so provided an excessive amount of lorazepam to be used daily together with
the high dose of trazodone.

178. Respondent’s medical records demonstrated an extreme departure from the standards of care in her care and treatment of Patient 4 when she prescribed both 20 mg of zolpidem in addition to 150 mg of trazodone. The maximum dose of zolpidem is routinely 10 mg and therefore combining this unusually high dose of zolpidem together with high dose trazodone could lead to excessive sedation.

179. Respondent’s medical records demonstrated an extreme departure from the standards of care in her care and treatment of Patient 4 when she prescribed the initial dose of 25 mg alprazolam in a quantity of 90 with three refills to a patient with no history of anxiety. Although Respondent’s assessment stated the patient had anxiety the medication is very habit forming and was repeatedly refilled by Respondent and her colleagues.

180. Respondent’s medical records demonstrated an extreme departure from the standards of care in her care and treatment of Patient 5 when she provided the patient with frequent refills of zolpidem together with hydrocodone and benzodiazepines.

181. Respondent’s medical records demonstrated an extreme departure from the standards of care in her care and treatment of Patient 5 when she again provided him with Xanax six months after Nurse Practitioner 2 advised the patient to use Prozac.

182. Respondent’s medical records demonstrated an extreme departure from the standards of care in her care and treatment of Patient 5 when instead of considering other methods of treating the patient’s anxiety she prescribed Xanax six months after Nurse Practitioner 2 advised the patient to use Prozac.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)
(Bus. & Prof. Code, § 2234, subd. (c))

183. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent committed repeated negligent acts in the care of her patients 1, 2, 3, 4 and 5. The circumstances are as follows:
The allegations of the First Cause for Discipline are incorporated herein by references as if fully set forth.

The standard of care in the community regarding prescribing long term opioids narcotics for treatment of non-cancer pain requires obtaining an adequate history and physical from the patient. The physician's assessment should include a thorough evaluation of pain, physical and psychological function and a substance abuse history. The physician should review the patient's history of prior pain treatment and assess the patient's underlying conditions related to pain. Documentation of the presence of a recognized medical indication for the use of a controlled substance should be clearly identified.

Respondent demonstrated a departure from the standard of care when she obtained and reviewed Patient 2's history and physical and failed to do more to explore the etiology of Patient 2's pain given that the patient's February 6, 2014, MRI showed a normal lumbar spine with no disc protrusion, foraminal narrowing, or spinal stenosis. Respondent failed to consider a rheumatologic workup when Respondent considered the patient's history and physical. The rheumatologic workup resulting in the diagnosis of polymyalgia rheumatica was not ordered by Respondent until April of 2017, three years after Respondent obtained her initial history and physical of Patient 2.

Respondent demonstrated a simple departure from the standard of care when she failed to emphasize the recommendations of Patient 4's previous pain management physicians. On the contrary Respondent continued to prescribe regular refills of opiate narcotics combined with benzodiazepines, carisoprodol and zolpidem to Patient 4.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
(Bus. & Prof. Code, §2234)

Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct. The circumstances are as follows:

The facts and circumstances set forth in paragraphs 16 through 165 are incorporated...
by reference as if set forth in full herein.
PRAYER

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

1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number 20A 6691, issued to Sherie Carnegie, D.O.;

2. Ordering her to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. If placed on probation, ordering her to pay to the Osteopathic Medical Board of California the costs of probation monitoring; and,

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

DATED: 12/20/19

MARK M. ITO
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant
DECLARATION OF SERVICE BY MAIL

In the Matter of the Accusation Against:

Sherie Carnegie, D.O.
Case No: 900 2016 000590

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

DECISION AND ORDER
STIPULATED SETTLEMENT AND DISCIPLINARY ORDER

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

NAME AND ADDRESS

Sherie Carnegie, D.O.
8142 Firestone Blvd.
Downey, CA 90241

Sherie Carnegie, D.O.
9489 0090 0027 6244 3731 97
8142 Firestone Blvd.
Downey, CA 90241
9489 0090 0027 6244 3732 03

Each said envelope was then, on July 27, 2020 sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid and return receipt requested.

Executed on July 27, 2020, at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

James C. Sparks
Typed Name

Signature

cc: Wendy Widlus, Deputy Attorney General
Richard A. Moss, Esq.