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

In the Matter of the Accusation Against:	)	
ERIC DAVID GORDON, M.D.	)	Case No. 12-2012-227503
Physician's and Surgeon's Certificate No. G82342	)	
Respondent	)	

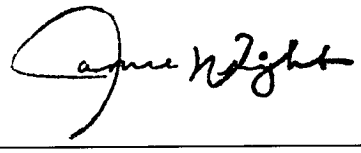
DECISION

The attached Stipulated Settlement and Disciplinary Order 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 December 16, 2016.

IT IS SO ORDERED: November 18, 2016.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D.
Chair, Panel A

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LYNNE DOMBROWSKI (State Bar No. 128080)
Deputy Attorney General
CAROLYNE EVANS (State Bar No. 289206)
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5578 (Dombrowski)
Telephone: (415) 703-1211 (Evans)
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **ERIC DAVID GORDON, M.D.** 3471 Regional Parkway Santa Rosa CA 95403 Physician's and Surgeon's Certificate No. G82342 Respondent.	Case No. 12-2012-227503 OAH No. 2016060898 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Lynne Dombrowski and by Carolyne Evans, Deputy Attorneys General.

2. Respondent Eric David Gordon, M.D. (Respondent) is represented in this proceeding by attorney Sharon Barclay Kime, whose address is Pacific West Law Group, LLP, Courthouse Square, 1000 Fourth Street, Suite 800, San Rafael, CA 94901.

3. On or about July 17, 1996, the Board issued Physician's and Surgeon's Certificate No. G82342 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 12-2012-227503 and will expire on January 31, 2018, unless renewed.

JURISDICTION

4. Accusation No. 12-2012-227503 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 October 16, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 12-2012-227503 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 12-2012-227503. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his 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 him; the right to present evidence and to testify on his 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 12-2012-227503, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that if he 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. 12-2012-227503 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.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

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

15. 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 Physician's and Surgeon's Certificate No. G82342 issued to Respondent Eric David Gordon, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any Schedule II controlled substances, as defined by the California Uniform Controlled Substances Act, until Respondent has successfully completed a course in Prescribing Practices, as specified in paragraph 4. Respondent shall submit to the Board or its designee a certification of successful completion of the course. This partial restriction shall remain in effect until Respondent has been notified in writing by the Board or its designee that the Board accepts that the requirement of a Prescribing Practices Course has been successfully completed.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. At least 20 hours of coursework annually shall pertain to the management of chronic pain. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at 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 prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices 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.

5. MEDICAL RECORD KEEPING COURSE. 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.

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are certified in pain medicine by the American Board of Medical Specialties (ABMS). A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall

make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

9. 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.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility. This restriction shall not apply to Respondent's three existing patients who are home-bound and who are seen by Respondent in their homes, provided that the patients' records are maintained and are available in Respondent's office.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

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

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or

jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order 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.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent

shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Sharon Barclay Kime. I understand the stipulation and the effect it will have on my 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 Medical Board of California.

DATED: 10/6/16

ERIC DAVID GORDON, M.D.
Respondent

I have read and fully discussed with Respondent Eric David Gordon, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 10.6.16

SHARON BARCLAY KIME
Attorney for Respondent

ENDORSEMENT

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

DATED: 10/07/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General

Lynne K. Dombrowski

LYNNE DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2015402390

Exhibit A

Accusation No. 12-2012-227503

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
LYNNE K. DOMBROWSKI
Deputy Attorney General
State Bar No. 128080
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5578
Facsimile: (415) 703-5480
E-mail: Lynne.Dombrowski@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Eric David Gordon, M.D.** 3471 Regional Parkway Santa Rosa CA 95403 Physician's and Surgeon's Certificate No. G82342, Respondent.	Case No. 12-2012-227503 **ACCUSATION**

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 (Board).

2. On or about July 17, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number G82342 to Eric David Gordon, 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 January 31, 2016, unless renewed.

3. At all times relevant to the allegations herein, Respondent was the sole owner of Gordon Medical Associates.

JURISDICTION

4. 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.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

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

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

7. Section 2242 of the Code states, in pertinent part:

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

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 725 of the Code states:

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

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

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"(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."

PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS

10. Abilify, a trade name for aripiprazole, is an anti-psychotic medication that is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It may also be used together with other medications to treat major depressive disorder in adults. It is a dangerous drug as defined in Business and Professions Code section 4022. Taking Abilify with other drugs that induce sleepiness can worsen the effect.

11. Actiq. See fentanyl.

12. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(32) and is a dangerous drug as defined in Business and Professions Code section 4022. It is indicated for the short-term treatment of insomnia. It is a central nervous system (CNS) depressant and should be used cautiously in combination with other CNS depressants. Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

13. Celexa, a trade name for citalopram, is an antidepressant in a group of drugs called a selective serotonin reuptake inhibitor ("SSRI") and it is used in the treatment of depression. It has primary CNS depressant effects and should be used with caution in combination with other centrally acting drugs. Celexa is a dangerous drug as defined in Business and Professions Code section 4022 of the Code.

14. Dilaudid, a trade name for hydromorphone hydrochloride, is a hydrogenated ketone of morphine and an opioid analgesic whose principal therapeutic use is for relief of pain. It is a

Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of opioids; therefore, Dilaudid should be prescribed and administered with caution. Patients receiving other opioid analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

15. Fentanyl is an opioid analgesic which can be administered by an injection, through a transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form (known as Fentora). It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. It is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and that requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. When patients are receiving fentanyl, the dosage of central nervous system depressant drugs should be reduced. Use of fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

16. HCTZ or hydrochlorothiazide is a diuretic and antihypertensive. It is indicated as an adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, corticosteroid and estrogen therapy, and various forms of renal dysfunction. It is also used in the management of hypertension, either as a sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension. It is a dangerous drug as defined in Business and Professions Code section 4022 of the Code.

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17. Hydrocodone bitartrate with acetaminophen, which is known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and is a Schedule II controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations[1], and is a dangerous drug as defined in Business and Professions Code section 4022.

18. Ketamine is a short-acting dissociative injectable anesthetic that has some hallucinogenic effects. It induces a trance-like state while providing pain relief, sedation, and memory loss. It is a Schedule III controlled substance, as defined by section 11056 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Although primarily used in humans as an anesthetic, it may also be used for post-operative pain management or to treat major depression. In some limited cases it may be used to treat complex regional pain syndrome but its use in treating non-cancer chronic pain is considered to be controversial or experimental. Ketamine may increase the effects of other sedatives, such as alcohol, benzodiazepines, opioids, and barbiturates. It also has a high potential for abuse and for diversion.

19. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions quantitatively similar to those of morphine. Methadone may be administered as an injectable liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics.

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[1] Effective 10/06/2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

20. MS Contin, a trade name for morphine sulfate, is an opioid pain medication indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Morphine is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Morphine is a highly addictive drug which may rapidly cause physical and psychological dependence and, as a result, creates the potential for being abused, misused, and diverted.

21. Nuvigil, a trade name for armodafinil, is a prescription medication indicated to improve wakefulness in adult patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy, or shift work disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

22. Opana, a trade name for oxymorphone hydrochloride, is an opioid analgesic indicated for the relief of moderate to severe acute pain. Oxymorphone is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and is a dangerous drug as defined in Business and Professions Code section 4022. Because respiratory depression is the chief hazard, oxymorphone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, tranquilizers, and alcohol.

23. OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. OxyContin is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. OxyContin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are

concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

24. Soma, a trade name for carisoprodol, is a muscle-relaxant and sedative. It is a Schedule III controlled substance as defined by section 11056, subdivision (e) of the Health and Safety Code and by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

25. Tramadol is an opioid agonist of the morphine-type that is indicated for the management of moderate to severe pain. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Tramadol may be expected to have additive effects when used in conjunction with alcohol, other opioids, or illicit drugs that cause central nervous system depression.

26. Valium, a trade name for diazepam, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

27. Xanax is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo-analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057, subdivision (d) of the Health and Safety Code, and by section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and is

a dangerous drug as defined in Business and Professions Code section 4022. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, Incompetence, Prescribing Without Appropriate Exam and Medical Indication, Excessive Prescribing re Patient PJ)

28. Respondent Eric David Gordon, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to patient PJ constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

29. Respondent first saw patient PJ in about December 1997 when the patient, a then 42-year-old male, was referred to him for possible alternative therapy for Hepatitis C, and for osteopathic manipulation and trigger point injections. Patient PJ had been disabled because of a back injury in about 1989 while working as a plumber, for which the patient underwent four low-back surgeries between 1989 and 1992. At that time, patient PJ had another physician who was managing his chronic pain.

30. In about mid-2005, Respondent took over responsibility for patient PJ's pain management, after the patient's former pain management physician closed her practice. According to Respondent, at that time patient PJ was being prescribed #30 Actiq 1600 mcg. lozenges monthly, as needed for pain flares and #7 tablets daily of MS Contin 200 mg. and Respondent continued this prescribing regimen.

31. During the course of treatment, since at least November 2008, Respondent has reported providing treatment for the following medical diagnoses for patient PJ: Lyme disease, lumbago, sciatica, neuropathic pain, chronic fatigue syndrome, and generalized pain.

32. On or about August 4, 2010, another physician completed an initial pain consultation report for patient PJ that was initiated by the patient's primary care physician, a copy of which is

in Respondent's records. In that report, the current medications for patient PJ are listed as: 5-7 tablets per day of MS Contin 200 mg.; Valium 10 mg. twice daily; Actiq (fentanyl lollypop) 600 mcg. a month, and hydrochlorothorizide (HCTZ). The consulting physician's conclusion was that the patient was adequately managed with this treatment.

33. On or about September 27, 2010, Respondent issued a prescription by telephone for patient PJ for #180 Valium (Diazepam) 10 mg. with instructions for two tablets to be taken three times daily that included five refills.

34. On or about October 1, 2010, Respondent issued to patient PJ a prescription for the following controlled substances: #210 MS Contin 200 mg. with instructions for 3-4 tablets to be taken twice daily; #210 Valium 10 mg. with instructions for 3 tablets to be taken twice daily; and #7 Actiq 1600 mcg. lozenges to be taken as needed (prn).

35. On October 26, 2010, Respondent renewed the prescriptions for #210 MS Contin 200 mg. and #7 Actiq 1600 mcg. lozenges.

36. Starting in or about February 2011, for a period of about four months, Respondent prescribed and dispensed a fentanyl nasal spray to patient PJ but there is inadequate documentation about the indication and dosing of this nasal spray. During those four months, from February 2011 through June 2011, Respondent also prescribed for patient PJ: Actiq, MS Contin, Diazepam, Opana ER 40 mg., and OxyContin.

37. For a visit on May 8, 2011, Respondent noted a Ketamine i.v. but the details of this treatment are not adequately documented in the patient's medical records.

38. On or about January 11, 2012, Respondent administered in his office to patient PJ 5,000 mcg. of fentanyl intravenously over thirty minutes without any result. Respondent then administered intravenously another 10,000 mcg. of fentanyl over a period of one hour and the patient had some relief.

39. In or about February 2012, Respondent began to treat patient PJ for Lyme disease with i.v. antibiotics and an i.v. port was placed in the patient.

40. On or about March 7, 2012, patient PJ saw Respondent for an office visit and Respondent administered 10,000 mcg of i.v. fentanyl.

41. On or about March 14, 2012, a nurse's note indicates that patient PJ came to the office and was administered 10,000 mcg. (1.0 ml.) of i.v. fentanyl infused over thirty minutes.

42. Although not adequately documented in the medical records, sometime in March 2012, Respondent gave patient PJ bags of fentanyl to take home and to self-administer via the i.v. port. A brief handwritten note dated March 16, 2012 from Respondent appears to instruct patient PJ to use no more than two 15, 000 mcg. bags a day, with each bag to be run over two hours. Respondent did not document in the patient's chart how many bags of i.v. fentanyl were dispensed and the medical indication for this prescribing.

43. On or about March 24, 2012, patient PJ saw Respondent for an office visit and Respondent administered intravenously 15,000 mcg. of fentanyl. Respondent noted that the patient reported that he was travelling to Dubai and to the Maldives for surfing.

44. A nurse's note dated March 27, 2012 documents that 1.5 cc. of fentanyl in a bag of Ringer's lactate was sent home with patient PJ, with no further information provided about the dispensing and instructions.

45. A nurse's note dated April 2, 2012 documents that three bags of Ringer's lactate with 1500 mcg. each of fentanyl was made up by Respondent and given to patient PJ to take on vacation.

46. A note dated April 4, 2012 documents a telephone request from patient PJ to pick up two bags of fentanyl on April 10, 2012 because he was leaving on April 11, 2012 for vacation. There is no documentation in the patient's chart as to whether the requested fentanyl was dispensed.

47. Respondent was aware that patient PJ was a surfer and that he continued to surf until sometime in about 2014.

48. From August 20, 2012 to October 1, 2012, Patient PJ was hospitalized at Santa Rosa Memorial Hospital with diagnoses of an infected port-a-cath, discitis, osteomyelitis, depression with suicidality, obsessive compulsive disorder with possible PTSD, a history of Lyme disease and of hepatitis C, narcotic bowel, and a septic sacroiliac joint. A psychiatric diagnosis during this hospital admission also listed somatoform disorder as an Axis I diagnosis.

49. According to a CURES report, on October 31, 2012, patient PJ filled prescriptions from Respondent for #180 MS Contin 200 mg. and #200 Valium 10 mg. and on the next day filled a prescription for #6 Actiq lozenges.

50. On or about November 6, 2012, Respondent saw patient PJ for an office visit and noted that the patient had been in the hospital for seven weeks because of severe low back pain. Respondent's chart note mentions that the patient is to taper off the methadone, without any further explanation.

51. On or about November 26, 2012, Respondent and patient PJ signed an agreement form for Risk Evaluation and Mitigation Strategy (REMS) for Actiq, a Transmucosal Immediate Release Fentanyl (TIRF) medicine. The REMS agreement specifically states that the prescriber understands that the TIRF medicine is indicated only for the management of breakthrough pain in patients with cancer who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent pain. Patient PJ was not being treated for cancer.

52. A nurse's note dated May 3, 2012 documents that patient PJ was given one 500 ml. bag Ringer's lactate with 60,000 mg. of fentanyl, with no additional information or explanation about the indication for this prescribing.

53. In March 2013, Patient PJ's i.v. catheter again became infected and the patient required hospitalization in Sebastopol for sepsis.

54. From at least January 1, 2012 through June 28, 2013, Respondent prescribed for patient PJ daily doses of about 1.2 grams of morphine equivalents and 60 mg. of diazepam.

55. On or about August 1, 2013, patient PJ saw Respondent for an office visit. The chart note indicates that the patient reported that he was now self-administering 60,000 mcg. of fentanyl in a 500 cc Ringer's lactate bag over a period of three hours. Although there is no documented medical indication and details about the prescribing and dosing instructions, it appears that patient PJ was also provided Dilaudid to take home for self-injection. Respondent's chart note for August 1, 2013 provides an incomplete list of what the patient was being prescribed.

56. In his interview with the Board's investigator, Respondent stated that it was his decision that patient PJ should administer all four bags of i.v. fentanyl at one time, so that the

patient would self-administer 60,000 mcg. of i.v. fentanyl on one night a week at home. Respondent, however, did not adequately document in the patient's chart the indication for this change in dosing and when the change was made.

57. According to Respondent, since about 2013 through to at least June 2015, patient PJ has been self-administering about 60,000 mcg. of i.v. fentanyl once a week, in addition to his other prescribed medications that consist of: MS Contin 200 mg., three tablets taken twice daily, Dilaudid 50 mg. intramuscular (IM) injections every other day, on an "as needed basis," and Valium 10 mg. up to 7 tablets daily.

58. According to the CURES report, in 2014 Respondent prescribed the following controlled substances to patient PJ: #1380 tablets of morphine sulfate 200 mg. time-extended release; #30 tablets of morphine sulfate 60 mg. time-extended release; #30 tablets of morphine sulfate 30 mg. time-extended release; #2800 tablets of diazepam 10 mg.; #900 tablets of Opana 40 mg. time-extended release; and an unknown quantity of fentanyl citrate powder provided on six separate dates.

59. Respondent's overall conduct, acts and/or omissions, with regard to patient PJ, as set forth in paragraphs 28 through 58 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient PJ as follows:

a. Respondent failed to document medical indications for his prescribing of controlled substances including, but not limited to, the high doses of opioids and the self-administered i.v. and IM opioids;

b. Respondent excessively prescribed controlled substances, particularly opioids, to patient PJ;

c. Respondent gave patient PJ fentanyl in extremely high doses to be administered intravenously at home, without proper monitoring;

d. Respondent prescribed controlled substances to patient PJ for chronic pain on an often irregular basis, with substantial breaks in the prescribing of controlled substances;

e. Respondent did not document in patient PJ's records that he discussed the risks and benefits of chronic opioid use with the patient, along with a discussion about other treatment modalities;

f. Respondent did not document any discussion with and education of patient PJ in the strict sterile protocols needed to be followed when using a permanent i.v. access line to administer medicines;

g. Respondent failed to adequately review the effectiveness of his treatments and continued to prescribe i.v. opioids to patient PJ, failing to consider the patient's two hospital admissions and the patient's very limited functional improvement with the treatment;

h. Respondent made no attempts to monitor the patient's chronic use of prescribed opioids;

i. Respondent failed to recognize and advise the patient of the risks involved with travelling outside the U.S. with high doses of controlled substances;

j. Respondent demonstrated a lack of knowledge in the proper use of opioids for the management of chronic pain;

k. Respondent's records are inadequate and incomplete and do not include sufficient information to explain medical decisions, documentation of appropriate physical examinations, a history of substance abuse, reports of functional status, accurate lists of current medications and current objective findings. The computer chart entries were often copied from previous visits, making it confusing and impossible to determine what information is current.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, Incompetence, Prescribing Without Appropriate Exam and Medical Indication, Excessive Prescribing re Patient DF)

60. Respondent is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to patient DF constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

61. Respondent first saw Patient DF in January 2001 because the patient was interested in antibiotic therapy for her mixed connective tissue disease. When he first saw patient DF she was a forty-six-year old female who had been unable to work for about twenty years due to her pain and was homebound. Patient DF presented with diagnoses of mixed connective tissue disease with a scleroderma component, ulcer disease, scoliosis, chronic headaches, and severe musculoskeletal pains.

62. According to the CURES report, between October 30, 2009 and November 15, 2013, Respondent prescribed daily to patient DF up to 360 mg. of morphine, a 100 mcg/hr. fentanyl patch, 160 mg. methadone, along with large doses of orally absorbed fentanyl and benzodiazepines.

63. On or about February 11, 2011, Respondent saw patient DF for an office visit and documented that the patient reported that she is functioning better with the pain meds. The chart indicated that the patient was using #15 Actiq 1600 mcg. lozenges daily, in addition to MS Contin, methadone, and other prescribed medications. No physical examination was documented.

64. On or about January 5, 2012, patient DF was admitted to Santa Rosa Memorial Hospital with an "altered level of consciousness" after being found unresponsive in her home.

65. Respondent continued to prescribe high doses of opioids after the patient was released from the hospital.

66. On or about April 19, 2012, patient DF signed an agreement form for Risk Evaluation and Mitigation Strategy (REMS) for Actiq, a Transmucosal Immediate Release

Fentanyl (TIRF) medicine, but there is no corresponding signed agreement by Respondent in the patient's chart.

67. On or about May 7, 2013, Respondent saw patient DF for an office visit at which the patient reported still being in pain after taking 20 Actiq lozenges per day, in addition to her other opiate medications.

68. On or about April 29, 2014, Respondent and patient DF signed an agreement form for Risk Evaluation and Mitigation Strategy (REMS) for Actiq, a Transmucosal Immediate Release Fentanyl (TIRF) medicine. The REMS agreement specifically states that the prescriber understands that the TIRF medicine is indicated only for the management of breakthrough pain in patients with cancer who are already receiving, and who are tolerant to, around-the-clock opioid therapy for their underlying persistent pain. Patient DF was not being treated for cancer.

69. Patient DF's last visit to Respondent's offices was on May 21, 2014. The patient was seen by another provider and given trigger point injections. Respondent continued to be the physician prescribing patient DF's medications.

70. Patient DF died at her home on July 31, 2014. Respondent completed and signed the death certificate, listing the cause of death as severe esophagitis, mixed connective tissue disease, and severe scoliosis.

71. According to the CURES report for six-months in 2014 (January 21, 2014 through July 23, 2014), Respondent prescribed and patient DF obtained the following controlled substances: #4,704 fentanyl citrate oral transmucosal lozenges 1600 mcg.; #90 fentanyl transdermal 100 mcg/hr. patches; #1440 morphine sulfate 30 mg. time-extended release tablets; #900 morphine sulfate 15 mg. time-extended release tablets; #1500 methadone hydrochloride 10 mg. tablets; #450 diazepam 10 mg. tablets; and, #150 zolpidem tartrate 5 mg. tablets.

72. Respondent's overall conduct, acts and/or omissions, with regard to patient DF, as set forth in paragraphs 60 through 71 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore

subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient DF as follows:

a. Respondent failed to document medical indications for his prescribing of controlled substances;

b. Respondent excessively prescribed controlled substances, particularly opioids and benzodiazepines, to patient DF;

c. Respondent did not adequately document in the patient's chart appropriate physical examinations with objective findings;

d. Respondent did not appear to acknowledge and re-consider the effectiveness of his treatments after the patient was hospitalized for being in an altered state or upon evidence that the patient's pain and function showed no improvement with the high doses of controlled substances;

e. Respondent failed to document that he informed patient DF of the risks and benefits of the chronic use of opioids and benzodiazepines;

f. Respondent demonstrated a lack of knowledge in the proper use of opioids for the management of chronic pain;

g. Respondent's records are inadequate and incomplete and do not include sufficient information to explain medical decisions, documentation of appropriate physical examinations, reports of functional status, accurate lists of current medications and current objective findings. The computer chart entries were often copied from previous visits, making it confusing and impossible to determine what information is current;

h. Respondent did not obtain and document a substance abuse history for patient DF;

i. Respondent made no attempts to monitor the patient's chronic use of prescribed opioids;

j. Respondent completed and signed the death certificate without acknowledging that the prescribed opioids and benzodiazepines may have contributed to patient DF's death.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, Incompetence, Prescribing Without Appropriate Exam and Medical Indication, Excessive Prescribing re Patient JE)

73. Respondent is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to patient JE constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

74. Respondent first saw patient JE in about February 1998 when the patient, a then forty-one-year-old female, was referred to him by a pain specialist for osteopathic manipulations and trigger point injections. The patient was disabled due to low back pain and sciatica. According to Respondent, patient JE presented to him with a twenty-year history of alcohol abuse but stated that she had stopped drinking in February 1998.

75. In about 2005, Respondent took over managing patient JE's pain and the prescribing of opiates. According to Respondent, at that time Patient JE was generally taking 120-150 mg. of morphine or oxycodone four times daily along with "very high doses of methadone and extraordinarily high doses of Xanax."

76. Since at least January 2011, Respondent has also prescribed testosterone cream to patient JE without documenting the medical indication and findings to support this prescribing.

77. On or about January 7, 2011, Respondent saw patient JE and noted that the patient realized that she was using Xanax like alcohol and that it was time to taper the Xanax and to get psychiatric advice for her medications.

78. Respondent saw patient JE in his office four times in 2011, three times in 2012, and three times in 2013.

79. According to the prescribing records, between October 30, 2009 through at least November 15, 2013, Respondent had prescribed to patient JE up to 800 mg. of methadone per day while at the same time prescribing daily 36 mg. of alprazolam and 720 mg. of oxycodone.

80. Respondent saw patient JE in his office seven times in 2014. She continued to get trigger point injections and osteopathic manipulation therapy (OMT).

81. On or about April 24, 2014, Respondent saw patient JE who reported that she was stable with her overall pain and that the medications allowed her to function, without providing further detail. Respondent's listed diagnoses for the visit included Lyme disease, sciatica, and lumbago/low back pain

82. During the course of his treatment and since at least January 2011, Respondent has not ordered an EKG or other tests to examine and assess the patient's complaints of back pain.

83. On or about June 24, 2014, Respondent recommended cannabis (marijuana for medical purposes) for patient JE without documenting the medical indication and without obtaining a substance abuse history.

84. On or about October 8, 2014, another physician saw and examined patient JE, observed that patient JE appeared over-sedated, and concluded that the patient was suffering many side effects from her current treatment of massive amounts of opiates. Respondent was provided a copy of the physician's report but did not change his prescribing to patient JE.

85. In a referral letter and summary dated October 20, 2014, Respondent reported that patient JE had a long history of myofascial pain and cervical and lumbar disc disease with long-standing right-sided sciatica. Respondent also reported that patient JE had a strong family history of depression and alcoholism and that she had been going to AA (Alcoholic's Anonymous) for over 25 years.

86. Respondent's records for patient JE include an email dated November 13, 2014 that stated that Respondent would no longer prescribe opioids to patient JE. There was no documented explanation for this decision in the patient's chart and it appears that Respondent issued prescriptions to patient JE in December 2014 for both methadone and oxycodone.

87. According to Respondent, he continues to treat patient JE but he is not her primary care physician.

88. According to the CURES report, in 2014 Respondent prescribed the following controlled substances to patient JE: #6480 tablets of methadone hydrochloride 10 mg.; #4140

tablets of oxycodone hydrochloride 30 mg.; #1320 tablets of alprazolam/Xanax 2 mg.; and an unspecified quantity of testosterone micronized powder on three separate dates. In addition, patient JE obtained from another physician in 2014: #1080 tablets of methadone hydrochloride 10 mg. and #720 tablets of oxycodone hydrochloride 30 mg.

89. Respondent's overall conduct, acts and/or omissions, with regard to patient JE, as set forth in paragraphs 73 through 88 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient JE as follows:

a. Respondent failed to document medical indications for his prescribing of controlled substances;

b. Respondent excessively prescribed controlled substances, particularly opioids, to patient JE;

c. Respondent did not appear to consider the patient's substance abuse history in his clinical decision making;

d. Respondent did not appear to acknowledge and re-consider the effectiveness of his treatments upon evidence that the patient's function did not improve with the high doses of controlled substances and/or that the patient was suffering many side effects from the opioids;

e. Respondent failed to document that he informed patient JE of the risks and benefits of the chronic use of opioids;

f. Respondent made no attempts to monitor the patient's chronic use of prescribed opioids;

g. Respondent demonstrated a lack of knowledge in the proper use of opioids for the management of chronic pain;

h. Respondent's records are inadequate and incomplete and do not include sufficient information to explain medical decisions, documentation of appropriate physical examinations,

reports of functional status, accurate lists of current medications and current objective findings. The computer chart entries were often copied from previous visits, making it confusing and impossible to determine what information is current.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, Incompetence, Prescribing Without Appropriate Exam and Medical Indication, Excessive Prescribing re Patient VT)

90. Respondent Eric David Gordon, M.D. is subject to disciplinary action under sections 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or omissions, with regard to patient VT constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

91. Respondent first saw patient VT in October 2004 when the patient was referred to him for assistance with mercury detoxification. Patient VT, a then 43-year-old female, presented with a history of muscle tension and migraine headaches. Patient VT had a primary care physician.

92. Respondent's records for patient VT indicate diagnoses of fibromyalgia, migraine, chronic fatigue, sleep apnea, tinnitus, hyperacusis, cervalgia, and common variable immunodeficiency.

93. Between October 2009 and June 2013, Respondent prescribed to patient VT the following controlled substances: hydrocodone 10/325 mg. four times daily; tramadol 50 mg. twice daily; Soma 350 mg. three times daily; Ambien 10 mg., up to two tablets per day; topical ketamine; and Nuvigil. Respondent also provided patient VT with prolotherapy, trigger point injections, chiropractic treatments, and complementary medicine treatments (ozone, detoxifications, chi machine, and non-allopathic medications.)

94. On or about April 25, 2011, Respondent noted in the office visit that ketamine nasal spray would be tried to treat the patient's hyperacusis but there is no documentation of what was dispensed to the patient and the dosing instructions. Respondent also prescribed Ambien in two different strengths (10 mg. and 12.4 mg) without documenting a recognized medical indication.

95. During the course of his treatment of patient VT, Respondent never documented the frequency and duration of the patient's migraine headaches.

96. In or about November 2011, patient VT had a consultation with a specialist about headaches and that physician recommended that the patient limit the use of Norco to no more than 10 days a month. Respondent received a copy of the report but did not change his prescribing of Norco to patient VT, which was about #90 tablets monthly.

97. According to the CURES report, in 2014 Respondent prescribed the following controlled substances to patient VT: #990 Ambien 10 mg. tablets; #900 tramadol hydrochloride 50 mg. tablets; #1440 carisoprodol (Soma) 350 mg. tablets; #1680 Norco 325 mg./10 mg. tablets; an unknown quantity of #37 ketamine hydrochloride powder; and #90 Nuvigil 150 mg.

98. According to Respondent, he continues to treat patient VT but he is not her primary care physician.

99. Respondent's overall conduct, acts and/or omissions, with regard to patient VT, as set forth in paragraphs 90 through 98 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient VT as follows:

a. Respondent prescribed excessively high doses of Ambien to patient VT without documenting a recognized medical indication;

b. Respondent did not document informing patient VT of the risks and benefits of the chronic use of opioids along with other treatment modalities;

c. Respondent made no attempts to monitor the patient's chronic use of prescribed opioids;

d. Respondent did not obtain and document a substance abuse history for patient VT;

e. Respondent's records are inadequate and incomplete and do not include sufficient information to explain medical decisions, documentation of appropriate physical examinations,

reports of functional status, accurate lists of current medications and current objective findings. The computer chart entries were often copied from previous visits, making it confusing and impossible to determine what information is current.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Inadequate and/or Inaccurate Medical Records re Patients PJ, DF, JE, and VT)

100. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to the provision of services to patient PJ and/or patient DF and/or patient JE and/or patient VT, as alleged in paragraphs 28 through 99, which are incorporated herein by reference as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re Patients PJ, DF, JE, and/or VT)

101. In the alternative, Respondent is subject to disciplinary action for unprofessional conduct, jointly and severally, under section 2234(c) for repeated negligent acts with regard to his acts and/or omissions with regards to patient PJ and/or patient DF and/or patient JE and/or patient VT, as alleged in paragraphs 28 through 99, which are incorporated herein by reference as if 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 G82342, issued to Eric David Gordon, M.D.;

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

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3. Ordering Eric David Gordon, 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 16, 2015

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

SF2015402390