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

In the Matter of the Accusation Against:	)	
GEORGE ROBERT SCHWARTZ, M.D. Physician's and Surgeon's Certificate No. G 23732	)	File No. 16-2006-174551)
Respondent	)	

DECISION

The attached **Stipulated Surrender of License** is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on **October 24, 2007 .**

IT IS SO ORDERED **October 17, 2007 .**

MEDICAL BOARD OF CALIFORNIA

By: _____
Barbara Yaroslavsky
Chair, Panel B
Division of Medical Quality

EDMUND G. BROWN JR., Attorney General
of the State of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against **GEORGE ROBERT SCHWARTZ, M.D.** P.O. box 1968 Santa Fe, NM 87504 Physician and Surgeon's Certificate No. G23732 Respondent.	**Case No.16-2006-174551** **STIPULATED SURRENDER OF LICENSE**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

1. David T. Thornton (Complainant) is the Executive Director of the Medical Board of California, and maintains this action solely in his official capacity. Complainant is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Jane Zack Simon, Deputy Attorney General.

2. George Robert Schwartz, M.D. (respondent) is represented in this proceeding by Robert F. Hahn of the Law Offices of Gould & Hahn, 3801 Christie Avenue, Emeryville, CA 94608.

3. Respondent has received, read, discussed with counsel and understands the Accusation which is presently on file and pending in case number 16-2006-174551, a copy of

which is attached as Exhibit A.

4. Respondent has carefully read, discussed with counsel and understands the charges and allegations in Accusation No. 16-2006-174551. Respondent also has carefully read and understands the effects of this Stipulated Surrender of License.

5. 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 be represented by counsel, at his own expense; 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.

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

7. Respondent agrees that based on the action taken by the New Mexico Medical Board as alleged in the Accusation, cause exists to discipline his California physician and surgeon's certificate pursuant to Business and Professions Code sections 141 and 2305. Respondent lives in New Mexico and has no present plans to return to California. He wishes to surrender his California license at this time.

8. Respondent understands that by signing this stipulation he is enabling the Medical Board of California to issue its order accepting the surrender of license without further process. He understands and agrees that Board staff and counsel for complainant may communicate directly with the Board regarding this stipulation, without notice to or participation by respondent or his counsel. By signing this stipulation, respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. In the event that this stipulation is rejected for any reason by the Board, it will be of no force or effect for either party. In the event that this stipulation is rejected for any reason by the Board, it will be of no force or effect for either party. The Board will not be disqualified from further action in this matter by virtue of its consideration of this

stipulation.

9. Upon acceptance of this stipulation by the Board, respondent understands that he will no longer be permitted to practice as a physician and surgeon in California, and also agrees to surrender and cause to be delivered to the Board any license and wallet certificate in his possession before the effective date of the decision.

10. The admissions made by respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

11. Respondent fully understands and agrees that if he ever files an application for relicensure or reinstatement in the State of California, the Board shall treat it as a petition for reinstatement, and respondent must comply with all laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed.

12. Respondent understands that he may not petition for reinstatement as a physician and surgeon for a period of three (3) years from the effective date of his surrender. Information gathered in connection with Accusation number 16-2006-174551 may be considered by the Division of Medical Quality in determining whether or not the grant the petition for reinstatement. For the purposes of the reinstatement hearing, the allegations contained in Accusation number 16-2006-174551 shall be deemed to be admitted by respondent, and respondent waives any and all defenses based on a claim of laches or the statute of limitations.

13. The parties understand and agree that facsimile copies of this Stipulated Surrender of License, including facsimile signatures thereto, shall have the same force and effect as the originals.

ACCEPTANCE

I have carefully read the above stipulation. I enter into it freely and voluntarily and with full knowledge of its force and effect, do hereby surrender my Physician and Surgeon's Certificate Number G23732 to the Division of Medical Quality, Medical Board of California, for

its formal acceptance. By signing this stipulation to surrender my license, I recognize tha its formal acceptance by the Board, I will lose all rights and privileges to practice as a phy and surgeon in the State of California and I also will cause to be delivered to the Board all license and wallet certificate in my possession before the effective date of the decision.

DATED: September 5, 2007

GEORGE ROBERT SCHWARTZ, M.D.
Respondent

APPROVAL

I have fully discussed with respondent George Robert Schwartz, M.D. the provision this Stipulated Surrender of License. I approve its form and content.

DATED: September 5, 2007

ROBERT F. HAHN
Law Offices of Gould & Hahn

Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License is hereby respectfully submitted consideration by the Division of Medical Quality, Medical Board of California.

DATED: _____.

EDMUND G. BROWN JR., Attorney General
of the State of California

JANE ZACK SIMON
Deputy Attorney General

Attorneys for Complainant

its formal acceptance. By signing this stipulation to surrender my license, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California and I also will cause to be delivered to the Board any license and wallet certificate in my possession before the effective date of the decision.

DATED: _____.

_____
GEORGE ROBERT SCHWARTZ, M.D.
Respondent

APPROVAL

I have fully discussed with respondent George Robert Schwartz, M.D. the provisions of this Stipulated Surrender of License. I approve its form and content.

DATED: _____.

_____
ROBERT F. HAHN
Law Offices of Gould & Hahn

Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California.

DATED: 9/6/07.

EDMUND G. BROWN JR., Attorney General
of the State of California

_____
JANE ZACK SIMON
Deputy Attorney General

Attorneys for Complainant

Exhibit A

BILL LOCKYER, Attorney General
of the State of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
JANE ZACK SIMON
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455 Golden Gate Avenue, Suite 11000
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Attorneys for Complainant

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

In the Matter of the Accusation Against:	**Case No. 16-2006-174551**
GEORGE ROBERT SCHWARTZ, M.D., P.O. Box 1968 Santa Fe, NM 87504 Physician and Surgeon's Certificate No. G23732 Respondent.	**ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant David T. Thornton is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about November 24, 1972, Physician and Surgeon's Certificate No. GG23732 was issued by the Board to George Robert Schwartz, M.D. (hereinafter "respondent").

///

Respondent's certificate will expire on January 31, 2008, but was **SUSPENDED** on May 16, 2006 pursuant to Business and Professions Code section 2310(a).

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state,

an agency of the federal government, or another country."

4. Respondent is subject to discipline within the meaning of section 141 and is guilty of unprofessional conduct within the meaning of section 2305 as more particularly set forth herein below.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On or about March 31, 2006, the New Mexico Medical Board issued its Findings of Fact, Conclusions of Law, Decision and Order revoking respondent's license to practice medicine in New Mexico. The New Mexico Board's action was based on findings that respondent issued prescriptions for controlled substances to numerous patients without maintaining adequate, accurate and complete medical records; he was unable to account for large quantities of controlled substances he obtained from pharmacies and manufacturing distributors; he engaged in injudicious prescribing, administering or dispensing of narcotics; he prescribed large quantities of Oxycontin for a patient when he was supposedly attempting to stop the patient's use of narcotics by prescribing Subutex; respondent made false, fraudulent and deceptive statements to the New Mexico Board regarding the existence or non-existence of his patient medical records, writing of prescriptions and his treatment of patients; respondent continued to prescribe Schedule II controlled substances after a hearing officer issued an order prohibiting him from prescribing Schedule II drugs, an intentional violation of the Order.

Attached hereto as Exhibit A is a true and correct copy of the Findings of Fact, Conclusions of Law, Decision and Order of the New Mexico Medical Board.

6. Respondent's conduct and the action of the New Mexico Medical Board as set forth in paragraph 5, above, constitute unprofessional conduct within the meaning of section 2305 and conduct subject to discipline within the meaning of section 141(a).

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G23732 heretofore issued to respondent George Robert Schwartz, M.D.;

2. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants;

3. Ordering respondent, if placed on probation, to pay the costs of probation monitoring upon order of the Division; and

4. Taking such other and further action as the Division deems necessary and proper.

DATED: June 5, 2006.

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Exhibit A

New Mexico Medical Board
2055 S Pacheco Street
Building 400
Santa Fe NM 87505
505-476-7220 Fax 505-476-7233

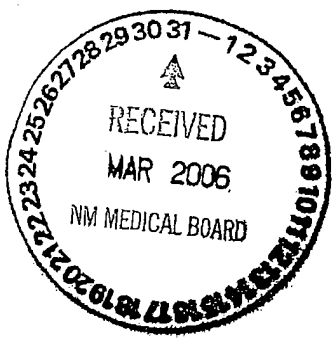
I, Lynn Hart, Executive Director of the New Mexico Medical Board, as a custodian of this record, certify that it is a copy accurately recorded, maintained and reproduced by this agency in accordance with the procedures attached hereto.

George Robert Schwartz, MD
NM License# 71-84
Public Action

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused the seal of the New Mexico Medical Board to be affixed, the day and year first above written.

SEAL

Lynn Hart
Executive Director
Records Custodian



BEFORE THE NEW MEXICO
MEDICAL BOARD

IN THE MATTER OF
GEORGE R. SCHWARTZ, M.D.,

Respondent.

Case. No. 2005-015

FINDINGS OF FACT, CONCLUSIONS OF LAW
DECISION AND ORDER
NOTICE OF RIGHT TO JUDICIAL REVIEW

THIS MATTER came before the New Mexico Medical Board ("Board") on March 30, 2006 for decision pursuant to provisions of the Uniform Licensing Act, §§ 61-1-1 to 61-1-33, NMSA 1978 (1957, as amended through 2003) and the Medical Practice Act, §§ 61-6-5(A) and 61-6-15(A), NMSA 1978 (1923, as amended through 2003).

The evidentiary hearing commenced before a duly appointed Hearing Officer on December 15, 2005. The case was continued until January 26-27, 2006 at Respondent's request. The parties did not conclude on January 27, 2006 and the case was recessed and reconvened on February 6, 2006. On January 24, 2006 the Administrative Prosecutor filed a motion to amend the NCA. Ex. 1-A. Respondent did not oppose the Amended NCA but sought a short continuance beyond January 26-27, 2006 to prepare. On January 27, 2006 the Hearing Officer granted the motion to amend. The Hearing Officer reconvened the hearing on February 6-7, 2006. The hearing concluded on February 7, 2006.

A quorum of the Board, having familiarized themselves with the transcript of the proceedings, exhibits admitted into the record, and the Hearing Officer's Report (with Appendix) dated March 9, 2006, voted unanimously to adopt the Hearing Officer's Report in its entirety (with Appendix), including the Hearing Officer's decisions on pre-hearing motions.

Pre-hearing Motions

1. *Respondent's Motion to disqualify Administrative Prosecutor.*

Respondent moved to disqualify the Administrative Prosecutor based on alleged misconduct. Having heard arguments of the parties (Tr. 45-51) and having listened to the telephone message from Respondent's prospective attorney (Tr. 51-52; Tr. 260-261), and finding no threat or intimidation by the prosecutor or evidence of ethical violation (Tr. 53).

The motion is DENIED.

2. *Respondent's Motion to Dismiss Counts 2(A), 2(G), 2(H), 2(I), and 2(J).*

Respondent filed a motion to dismiss counts 2 (A), (G), (H), (I), and (J). The Hearing Officer ruled that the motion addresses the facts in dispute, which is the purpose of the hearing. The factual issues are to be determined based on the evidence presented by the parties at the hearing. Tr. 39, 60.

The motion is DENIED.

3. *Administrative Prosecutor's Motion to Amend NCA.*

On January 24, 2006, the Administrative Prosecutor filed a motion to amend the NCA to add charges alleging that Respondent violated the Hearing Officer's Order

dated December 23, 2005. The Order reflected the voluntary agreement by Respondent on December 15, 2005 not to prescribe schedule 2 and schedule 3 drugs pending the decision of the Board. Tr. 21. By the agreement, the Hearing Officer granted a continuance from December 15-16, 2005 to January 26-27, 2006. Respondent did not object to the amended NCA, but sought a short continuance to prepare. See *Respondent's Letter dated January 25, 2006.*

The motion to amend the NCA is GRANTED. (References herein to the NCA shall mean the NCA, as amended.)

Administrative Prosecutor's Motion to Dismiss Allegations

During the course of the proceedings the Administrative Prosecutor filed an oral motion to dismiss allegations 2(K), 2(L), and 2(M).

These allegations are DISMISSED.

FINDINGS OF FACT

The Board adopts the Hearing Officer's recommended findings of fact numbered 1-29 as follows:

1. George R. Schwartz, M.D., ("Respondent") is licensed by the Board to practice medicine in New Mexico and is subject to the jurisdiction of the Board.

2. The NCA was initiated on July 12, 2005. Ex. 1. The text shown in *italics* is the verbatim text of allegations contained in the NCA, as amended.

3. Respondent requested a hearing. Ex. 2.

4. The evidentiary hearing commenced on January 26-27, 2006 in accordance with a notice of hearing. Ex. 3. The NCA was amended by order of the

Hearing Officer and the hearing continued on February 6-7, 2006. See *Notice* dated January 31, 2006.

5. On June 10, 2004, Respondent reported a burglary to the Santa Fe police that occurred overnight on June 9-10, 2004. Exs. 15; 20. Respondent reported a safe was stolen from a pick up truck, along with other personal items. Ex. 15. The police officer who took the report did not list medical records as missing and did not remember mention of medical records being reported to him as missing at the time the report was taken. Deposition, Ex. 20, p. 6; Deposition Ex. 15-A. At the hearing, Respondent testified that the safe contained medical records. Ex. 15. Several witnesses, including Respondent's daughter and two part time employees, testified on Respondent's behalf that Respondent had medical records and the medical records were kept in a safe. Tr. 432-433, 487. Respondent did not report any drugs missing or stolen. Ex. 15; Deposition, Ex. 20, p. 6; Deposition Ex 15-A.

6. Respondent contends that he did not write all the prescriptions that are the subject of the NCA.

7. On October 24, 2005 Respondent went to the Board office and examined original prescriptions written on Respondent's Rx pad and bearing Respondent's signature written for five patients that form the basis for the allegations in the NCA involving injudicious prescribing of drugs and failure to maintain adequate medical records that justify the prescriptions written for the patients. Tr. 199-200; Ex. 14.

8. These five patients have the same surname. Ex. 51. Patient #2 is the mother of Patient #1. Patient #3 is the brother of Patient #1. Tr. 152. Patient #1

regularly picked up the prescriptions for Patient #2 and Patient #3. Ex. 53. Respondent prescribed controlled substances as though he was prescribing for management of severe chronic pain for all five members of the group, all bearing the identical surname. Patient #1 regularly signed for the prescriptions at the pharmacy for others. Ex. 53.

9. Respondent examined the original prescriptions and separated from the prescriptions those prescriptions Respondent said he did not write. Ex. 13; Tr. 201-202. Respondent did not deny writing the remaining prescriptions. Ex. 12, Tr. 206.

10. Whether Respondent wrote the prescriptions that are the subject of the allegations is relevant to the question whether Respondent violated certain provisions of the Medical Practice Act as alleged in the NCA. Specialized expert opinion testimony will assist the triers of fact to understand the evidence and to resolve disputed questions of fact.

11. The Administrative Prosecutor called Thomas Earl Van Valkenburgh to testify as an expert witness. Tr. 345.

12. Mr. Van Valkenburgh is qualified as a forensic handwriting expert by knowledge, skill, experience, training, and education to present testimony in the form of an opinion concerning whether Respondent wrote the disputed prescriptions. Tr. 354; See also *Appendix to Hearing Officer's Report*, incorporated herein by this reference.

13. Mr. Van Valkenburgh testified that in his opinion Respondent wrote the prescriptions that Respondent said he did not write. Tr. 352; Exs. 21-A; Ex. 21; Appendix.

14. Respondent wrote and signed all the questioned document prescriptions that Respondent said he did not write. Exhibits 21, 21-A, and 21-B; Tr. 352.

15. The prescriptions were done by individual hand, not by machine. Tr. 395.

16. **Allegation 2(A)** - violation of § 61-6-15(D) NMSA 1978, unprofessional or dishonorable conduct for failure to maintain timely, accurate, and complete medical records.

Respondent did not maintain adequate medical records for at least 55 patients to whom he prescribed and/or dispensed controlled substances from at least March of 2001 until at least July of 2003, identified in a log he provided to the United States Drug Enforcement Administration.

(a) Michelle Daugherty, a Diversion Investigator with the Drug Enforcement Administration, Albuquerque, conducts audits of doctors in order to account for drugs the doctor has ordered from manufacturers and distributors. Tr. 86-87.

(b) Ms. Daugherty served a Notice of Inspection. Tr. 103; Ex. 52.

(b) Respondent ordered and obtained controlled substances. Tr. 87; Ex. 5-7.

(c) Respondent is responsible to account for all controlled substances obtained by him for the audit period.

(d) Ms. Daugherty did an inventory of drugs. Respondent could not account for all the drugs. Tr. 91; Ex. 7.

(e) Drugs that are ordered and are not accounted for by inventory of drugs on hand can be accounted for if Respondent dispensed the drugs to patients. Tr. 93.

(f) Respondent produced what he calls a pharmacy log purporting to account for the drugs he dispensed to patients. Tr. 94; Ex. 4.

(g) The pharmacy log (Ex. 4) consists of a list of numbers (non-sequential numbers 001 - 074) purporting to represent patients, followed by dates and lists of drugs. Tr. 95; Ex. 4. The pharmacy log does not contain patients' medical histories, record of physical examinations, vital signs, diagnoses, treatments, patient-reported outcomes of treatments, any laboratory tests ordered or their results, information from other treating health care practitioners, or other information that is minimally necessary to constitute an adequate patient medical record. Ex. 4.

(h) Ms. Daugherty asked for the patients' medical records to account for controlled substances that Respondent said he dispensed to the patients, in order to verify that the patients received the controlled substances Respondent said he dispensed. Tr. 95, 106; 112. The only way to verify that an actual person received the controlled substances is to review the medical records. Tr. 95, 112.

(i) Respondent knew or should have known he had a duty to produce medical records to the DEA. Respondent did not produce the medical records requested by the DEA. If Respondent had adequate records, it is logical that he would have produced them to the DEA in order to verify that he actually dispensed the drugs to patients. Respondent did not produce medical records regarding patients listed on the pharmacy log. Tr. 102.

(j) Examples of Respondent's written medical records prior to July 2003 are

included in Ex. 16. The writings are illegible and incomplete and are either separated from other records or integrated with other patients' record. Ex. 16.

(k) Respondent did not maintain adequate medical records for patients to whom he prescribed or dispensed controlled substances from March 2001 to July 2003.

17. **Allegation 2(B)** - violation of §61-6-15(D)(12), gross negligence.

Respondent obtained in excess of 1,000 doses of controlled substances from pharmacies and from manufacturing distributors from 2002-2003 that he cannot account for in his medical and inventory records.

(a) Ms. Daugherty conducted an audit of controlled substances ordered by Respondent for the period from July 30, 2002 to July 30, 2003. Tr. 87. Ms. Daugherty served Respondent with a Notice of Inspection on June 30, 2003. Tr. 134; Ex. 52.

(b) Between July 30, 2002 and July 30, 2003, Respondent was unable to account for 2,700 doses of controlled substances. Tr. 91, Ex. 7.

(c) Ms. Dougherty conducted an inventory of controlled substances maintained at Respondent's registered DEA location, which was his residence. The inventory was conducted *before* June 9, 2004, the date of the reported burglary. Tr. 92.

(d) Ms. Daugherty counted the drugs on hand with Respondent present. Tr. 101.

(f) Respondent was unable to account for large quantities of drugs, either through patient medical records or his inventory of drugs, from 2002 to the present. Tr. 113.

18. **Allegation 2(C)** - violation of §61-6-15(D) NMSA 1978, unprofessional or dishonorable conduct for failure to maintain timely, accurate and complete medical records.

Respondent did not maintain adequate medical records for Patient #1 that justified his prescription of large quantities on Hydrocodene/APAP 7.5>500 mg , Oxycontin 40 mg., Phentermine and Dextroamphetamines from at least March of 2002 until March of 2003.

(a) The interest of the patient is paramount in the practice of medicine.

(b) Board Rule 16.10.14 NMAC, Management of Chronic Pain with Controlled Substances, establishes mandatory guidelines to be used by licensees in the interest of public health, safety and welfare in prescribing, administering, or dispensing controlled substances to meet the individual needs of the patient for management of chronic pain. The guidelines require record keeping practices that include, without limitation: physical examination, medical history, individually tailored written treatment plan stating objectives and evaluation measures, and long-term monitoring.

(c) Board Rule 16.10.14.8(C) states in part that "[t] he Board will judge the validity of prescribing based on the practitioner's treatment of the patient and on available documentation....." Without timely, accurate, and complete medical records documenting treatment, Respondent cannot justify the large quantities of controlled substances prescribed to patients for chronic pain.

(d) Adherence to the guidelines is necessary to determine whether the prescriptive practices are consistent with the appropriate treatment of pain.

(e) Respondent is required to comply with Board rules, including Board Rule 16.10.14.8, when prescribing controlled substances to treat chronic pain.

(f) Respondent had an intimate relationship with Patient #1. The personal relationship involved Respondent giving Patient #1 access to his personal finances. Respondent denied having a sexual relationship with Patient #1. Tr. 572; Ex. 26.

(g) Respondent's personal relationship with Patient #1 may explain why Respondent failed to comply with the guidelines for management of chronic pain. Personal relationships with patients cloud professional judgment and are detrimental to the best interests of the patient.

(h) Respondent did not maintain adequate medical records for Patient #1 that justified prescribing large quantities of Oxycontin from March 2002 to March 2003.

19. **Allegation 2(D)** - violation of §61-6-15(D)(26) NMSA 1978, injudicious prescribing, administering or dispensing any drug or medicine.

From at least July of 2004 until April of 2005, Respondent prescribed large quantities of 5 mg. Dexedrine for Patient #1 that were not medically indicated.

(a) Dexedrine is a potentiating agent for analgesics and is medically indicated to potentiate the effects of Oxycontin. Tr. 168.

(b) The Administrative Prosecutor did not present evidence that the prescriptions for Dexedrine for Patient #1 were not medically indicated to potentiate the effects of Oxycontin.

20. **Allegation 2(E)** - violation of §61-6-15(D)(33), failure to maintain timely, accurate and complete medical records.

Respondent did not maintain adequate medical records for Patient #1 from at least July of 2004 until April of 2005 that justified his prescriptions of large quantities of 5 mg. Dexedrine.

(a) The reported burglary occurred overnight on June 9-10, 2004. Ex. 20.

(b) Respondent was responsible to maintain records in accordance with Board Rule 16.10.14 for patients he treated for chronic pain after the burglary.

(c) Exhibit 16 contains examples of Respondent's medical record keeping. There is a paucity of medical records for Patient #1.

(d) Respondent did not maintain medical records for Patient #1 that comply with Board Rule 16.10.14 NMAC. See Recommended FOF 18(a)-(e).

21. **Allegation 2(F)** - violation of §61-6-15(D)(33), failure to maintain timely, accurate and complete medical records.

Respondent did not maintain adequate medical records for Patient #1 that justified his prescribing of large quantities of Oxycontin 80 mg. in 2005.

(a) Based on the testimony of the expert forensic document examiner, Respondent wrote the prescriptions for Patient #1 dated between January 2005 to June 2005.

(b) Patient #1 signed for and received prescriptions between January 2005 and June 2005. Exs. 8, 9, 10.

(c) Eloy E. Aragon, pharmacist, owns Plaza Drug in Las Vegas. Tr. 137.

(d) Mr. Aragon knows Patient #1 by sight. Tr. 147-148.

(e) Mr. Aragon knows Respondent's voice. Tr. 149.

(f) Two prescriptions that Respondent denies writing were filled for Patient #1 by Mr. Aragon at Plaza Drug after Mr. Aragon called Respondent to confirm the prescription and received oral authorization from Respondent to fill the prescription. Tr. 149-150.

(g) Respondent prescribed Oxycontin to Patient #1 in 2005, ostensibly for pain relief. Tr. 577, Exs. 8, 9, 10. Patient #1 did not always fill the prescriptions in the quantities prescribed.

(h) Respondent's medical records for Patient #1 identified for March, April, and May 2005 are not adequate medical records in that the records do not meet the requirements of Board Rule 16.10.14 NMAC. Ex. 16; Recommended FOF 18(a)-(e).

22. **Allegation 2(G)** - violation of §61-6-15(D)(33), failure to maintain timely, accurate and complete medical records.

Respondent did not maintain adequate medical records for Patient #2 from at least July of 2004 until April of 2005 that justified his prescription of large quantities of Oxycontin 80 mg.

(a) Respondent treated Patient #2 and continued to prescribe large quantities of Oxycontin after June 2004. Ex. 30. Even if medical records were stolen in June 2004, Respondent was responsible after June 2004 to maintain records for Patient #2 in accordance with Board Rule 16.10.14 NMCA. Recommended FOF 18(a)-(e).

(b) Without medical records, Respondent cannot justify the prescribing of large quantities of Oxycontin to Patient #2.

(c) Respondent did not maintain adequate medical records for Patient #2 from July 2004 to April 2005 that comply with the requirements of Board Rule 16.10.14 NMAC.

23. **Allegation 2(H)** - violation of §61-6-15(D)(26), injudicious prescribing, administering or dispensing any drug or medicine.

From at least May of 2004 until at least January of 2005, Respondent prescribed large quantities of 80 mg. Oxycontin for Patient #3 that were not medically indicated.

(a) From May 2004 to January 2005, Respondent prescribed large quantities of Oxycontin to Patient #3. Ex. 30, Ex. 53, p. 3.

(b) Without adequate medical records that are kept in accordance with Board Rule 10.16.14, Respondent cannot justify prescribing Oxycontin for the management of chronic pain. Recommended FOF 18(a)-(e).

(c) Respondent cannot provide records that indicate that Oxycontin was medically indicated for Patient #3 for the management of chronic pain.

24. **Allegation 2(I)** - violation of §61-6-15(D)(33), failure to maintain timely, accurate and complete medical records.

Respondent did not maintain adequate records for Patient #3 from at least July of 2004 until at least April of 2005 that justified his prescriptions of large quantities of 80 mg. Oxycontin.

(a) Recommended findings of fact numbered 23(a)-(c) are incorporated herein. See Recommended FOF 18(a)-(e).

(b) Respondent did not maintain adequate records for Patient #3 from July 2004 to April 2005 that justify prescribing Oxycontin for chronic pain management or other medical purpose.

25. **Allegation 2(J)** - violation of §61-6-15(D)(26), injudicious prescribing, administering or dispensing any drug or medicine.

Respondent prescribed large quantities of 80 mg. Oxycontin for Patient #3 from January of 2005 to at least April of 2005 when he was supposedly attempting to stop the patient's use of narcotics by prescribing Subutex for the patient.

(a) Respondent prescribed large quantities of Oxycontin to Patient #3 from January 2005 to April 2005. Exs. 18, 30.

(b) Patient #3 was taking Subutex. Tr. 177; Ex. 18.

(c) Respondent has a special certification and is one of a few doctors certified as an Opioid Based Office Treatment (OBOT) doctor. Respondent is authorized to prescribe Subutex to addicts in an outpatient basis. Tr. 100, 131.

(d) Patients taking Subutex should not be prescribed Oxycontin. If Respondent is treating Patient #3 with Subutex for addiction, Respondent should have known that the Oxycontin was contraindicated and that the Oxycontin may have been diverted.

26. **Allegation 2(N)** - violation of §61-6-15(D)(15), the use of false, fraudulent, or deceptive statement in any document connected with the practice of medicine.

On or about April 23, 2004, Respondent wrote the Board and stated that he had "for all practical purposes shut down the private practice I had." When Respondent made the statement, he knew it was not true as he continued, on a regular bases (sic), wrote prescriptions for large quantities of narcotics for at least Patients 1, 2, and 3

(a) Respondent wrote to the Board on or about April 23, 2004, that he, for all practical purposes, shut down his private practice. Other statements in the letter concerning his practice were equivocal. Ex. 26, p. 4.

(b) The statement may have been true in April 2004. After April 2004, Respondent may have changed his mind.

(c) There is insufficient evidence that Respondent was false, fraudulent, or deceptive when he wrote the letter to the Board on April 23, 2004.

27. **Allegation 2(O)** - violation of §61-6-15(D)(15), false, fraudulent or deceptive statement in any document connected with the practice of medicine and Board Rule 16.10.8.8(H) NMAC, dishonesty.

On or about April 8, 2005, Respondent wrote to the Board and stated that he could not provide the Board with certain medical records, "because all my medical records have been stolen." When Respondent made the statement, he knew it was not true

(a) After the burglary, Respondent knew he had some medical records.

(b) By April 2005, Respondent had discovered some records and had prepared other patient records.

(c) Respondent's statement lacked candor.

28. **Allegation 2(P)** - violation of §61-6-15(D)(15), false, fraudulent or deceptive statement in any document connected with the practice of medicine and Board Rule 16.10.8.8(H), dishonesty.

On or about July 8, 2005, Respondent provided the Board with his medical records regarding Patient #3. The records were misleading and deceptive. They reflect that he was treating the patient beginning January of 2005, to facilitate his withdrawal from the use of narcotics while Respondent was actually prescribing large quantities of Oxycontin 80 mg to the patient.

(a) Respondent's medical records pertaining to Patient #3 indicate that Patient #3 was being treated with Subutex. Exs. 18, 30, 53.

(b) Respondent continued to prescribe large quantities of Oxycontin to Patient #3 while prescribing Subutex. Exs. 30, 53.

(c) Respondent's medical records regarding Patient #3 are inaccurate and are therefore misleading and deceptive.

29. **Allegation 2(Q)** - violation §61-6-15(D)(29), conduct unbecoming in a person licensed to practice medicine.

On December 15, 2005, you agreed to not prescribe Schedule II drugs until the Board made a decision in the case. You knew that the Hearing Officer entered an Order that incorporated your agreement and ordered you not to prescribe Schedule II drugs until the Board made a decision in the case.

On December 15, 2005, you wrote prescriptions for Patient #1 for Oxycontin and Dexedrine. On January 14, 2006, you wrote prescriptions for Patient #4 for Oxycontin.

You also wrote a prescription for Oxycontin for Patient #5 on January 21, 2006 and for Patient #1 on January 23, 2006. These are Schedule II drugs.

(a) The evidentiary hearing in the case was set to commence on December 15, 2005. On December 15, 2005, Respondent voluntarily agreed not to prescribe schedule 2 drugs until the Board made a decision in the case. Tr. 21; letter dated December 16, 2005. The Hearing Officer granted a continuance in the case based on the terms of the voluntary agreement. See *Order Granting Continuance With Voluntary Consent to Limit Prescribing of Schedule 2 and Schedule 3 Drugs, dated December 23, 2005.*

(b) Subsequent orders dated December 30, 2005 and January 17, 2006 reiterated and affirmed the agreed-to prescribing restrictions.

(c) Respondent prescribed schedule 2 drugs to patients on and after December 15, 2005. Specifically, Respondent wrote two (2) prescriptions on December 15, 2005, three (3) prescriptions on January 14, 2006, one (1) prescription on January 21, 2006 and one (1) prescription on January 23, 2006.

(d) Respondent intentionally violated his voluntary agreement and the Hearing Officer's Order. Based on the fact that Respondent intentionally violated the voluntary agreement on the day he made the agreement, within hours of at the time Respondent stated on the record that he would not prescribe schedule 2 and schedule 3 drugs, Respondent did not intend to comply with is agreement.

(g) Honesty and integrity are essential to the ethical practice of medicine.

CONCLUSIONS OF LAW

Based on the findings of fact, the Board reaches the following conclusions of law:

1. The Board has jurisdiction over Respondent and the subject matter.

2. The Board has complied with all notice and hearing requirements of the Uniform Licensing Act and has afforded Respondent all due process required by law. This decision is timely rendered.

3. Pursuant to § 61-1-15(A) and Rule 16.10.5.9 NMAC, the Board has authority to take disciplinary action, including license revocation, against the holder of a license upon satisfactory proof being made that the licensee is guilty of unprofessional or dishonorable conduct.

3. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(A) of the NCA.

4. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(12), gross negligence, as alleged in ¶ 2(B) of the NCA.

5. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(C) of the NCA.

6. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(33), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(E) of the NCA.

7. The Board has sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(33), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(F) of the NCA.

8. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(33), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(G) of the NCA.

9. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(26), injudicious prescribing, administering, or dispensing any drug or medicine, as alleged in ¶ 2(H) of the NCA.

10. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(33), failure to maintain timely, accurate, and complete medical records, as alleged in ¶ 2(I) of the NCA.

11. The Board concludes that there is sufficient evidence in the record to prove by a preponderance of the evidence that Respondent violated § 61-1-15(D)(26),

injudicious prescribing, administering, or dispensing any drug or medicine, as alleged in ¶ 2(J) of the NCA.

12. The Board concludes that there is sufficient evidence in the record to prove by clear and convincing evidence that Respondent violated § 61-1-15(D)(15), false, fraudulent, or deceptive statement in any document connected with the practice of medicine, as alleged in ¶ 2(P) of the NCA.

11. The Board concludes that there is sufficient evidence in the record to conclude that Respondent violated § 61-6-15(D)(29), conduct unbecoming in a person licensed to practice medicine, as alleged in ¶ 2(Q) of the NCA.

DECISION AND ORDER

Based on the findings of fact and conclusions of law, the Board renders this Decision and Order.

IT IS ORDERED that Respondent's license to practice medicine is and shall be permanently REVOKED effective April 7, 2006. Upon the effective date of revocation, Respondent shall not, directly or indirectly, engage in the practice of medicine in New Mexico as described in the Medical Practice Act or attempt or offer to practice medicine in New Mexico, including, without limitation, providing, directly or indirectly, medical care to any person or providing, dispensing, administering, or prescribing any drug to any person.

This action is disciplinary action and is a public record pursuant to the Inspection of Public Records Act and shall be reported to the National Practitioners Data Bank

(NPDA), the Healthcare Integrity and Protection Data Bank (HIPDP), and any other appropriate entities.

This Decision and Order shall be served upon Respondent in accordance with law. A notice informing Respondent of his right to seek judicial review and the time within which review must be brought is attached hereto and incorporated herein by this reference.

Steven Weiner, M.D., Secretary-Treasurer, is designated to sign the Decision and Order of the Board.

FOR THE NEW MEXICO
MEDICAL BOARD

Date: March 31, 2006

Steven Weiner, M.D.