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

In the Matter of the Accusation Against: **KURT EUGENE JOHNSON, M.D.** 1040 Mangrove Ave. Chico, CA 95926-3598 **Physician's and Surgeon's Certificate No. G 59768,** Respondent.	Case No. 800-2014-009678 **A C C U S A T I O N**

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 March 23, 1987, the Medical Board issued Physician's and Surgeon's Certificate Number G 59768 to Kurt Eugene Johnson, 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 October 31, 2018, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides 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.

5. 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."

6. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent Kurt Eugene Johnson, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he engaged in acts of gross negligence. The circumstances are as follows:

9. Respondent is a family practice physician who has practiced pain management with respect to several long-term patients.

10. The standard of care for pain management requires a medical history and physical examination to include assessment of the patient's pain including physical and psychological status and function, substance abuse history, and history of prior pain treatments and assessment of underlying or co-existing conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances such as opiates for pain control.

11. The standard of care for pain management requires that medical records contain stated objectives that may include relief from pain or improved physical or psychological function or ability to perform certain tasks or activities of daily living. This should also include any plans for further diagnostic evaluations and treatments, such as a rehabilitation program.

12. The standard of care for pain management requires the medical records document that the physician discussed the risks and benefits of the use of controlled substances along with other treatment modalities. An actual written consent is not required but is recommended.

13. The standard of care for pain management requires that the medical records reflect that the physician is periodically reviewing the course of pain management for the patient and making appropriate modifications in the treatment based on the patient's progress or lack of progress.

14. The standard of care for pain management requires that the physician consider additional evaluations or consultations, especially with complex pain problems. Special attention should be given to patients who are at risk for misusing their medications or have a history of drug addiction or substance abuse. Such patients require extra care and monitoring along with documentation and consultation with an addiction medicine specialist and pain management specialist.

15. The standard of care requires that a physician maintain accurate and complete records, demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation.

Circumstances related to B.B.

16. B.B. was a female patient whom Respondent treated for chronic pain since at least 2001, until she died in October, 2014. She was 73 years old at the time of death. During the time that Respondent was her treating physician, Respondent prescribed a wide variety of controlled substances to B.B. on a continuing basis.

17. On or about September 5, 2011, B.B. was hospitalized for a left hip fracture. She had open reduction and internal fixation, and was discharged on or about September 10, 2011.

18. On or about October 12, 2011, B.B. saw Respondent for a follow-up appointment. Respondent documented a medication list consisting of 32 different medications. Respondent documented a psychiatric examination showing that B.B. was oriented as to time, place, and person, and had an appropriate mood. Respondent documented a focused examination of the extremities, showing generalized tenderness and foot onychomycosis (a fungal infection of the toenails or fingernails.) However, Respondent failed to document a physical examination related to the patient's chronic pain, to include range of motion and muscle spasm, or any examination of the patient's shoulder or back. Nonetheless, Respondent diagnosed B.B. with osteoarthritis, shoulder pain, discogenic disease, and Lyme disease. Respondent's documented treatment plan with respect to chronic pain was simply to continue the patient's medication, without any stated objectives. Respondent failed to document a rationale for prescribing two different opiates at the

same time: Kadian[1], and Percocet.[2] Respondent gave B.B. a refill of most of her medications, including Kadian, Percocet, and Adderall.[3] She was to return in two to three months.

19. On or about June 6, 2012, B.B. was seen for follow-up for chronic pain and general fatigue. Respondent documented a medication list with 27 different medications. Respondent again failed to document any examination of the spine or shoulders. Respondent gave B.B. refills of Adderall, Clonazepam[4], Kadian, and Promethazine[5].

20. On or about October 17, 2012, B.B. signed a pain management agreement.

21. On or about February 20, 2013, B.B. was seen by Respondent for refills on her medications. Respondent documented chronic pain and general fatigue. Respondent failed to document any examination of the shoulders or back.

22. On or about April 3, 2013, Respondent saw B.B. for follow-up regarding arthritis pain in her wrists, hips, back, and shoulders. Respondent documented examination of the extremities based on generalized arthritic changes. Respondent documented a neurological examination. Respondent refilled B.B.'s prescriptions for Adderall, morphine, and Fentanyl.[6]

23. On or about January 15, 2014, Respondent saw B.B. for complaints of chronic back pain and excessive sleeping. Respondent documented shoulder arthritis. Respondent documented an unremarkable neurological and psychiatric examination. Respondent's assessment was opioid-induced sleep disorder, attention deficit disorder, and osteoarthritis.

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[1] Kadian is a brand name for extended release morphine sulphate, an opioid medication for the treatment of moderate to severe pain used when around the clock pain relief is needed.

[2] Percocet is the brand name for a preparation of acetaminophen and the opioid oxycodone, used for the treatment of pain.

[3] Adderall is the brand name for amphetamines, a stimulant used to treat attention deficit hyperactivity disorder.

[4] Clonazepam is a benzodiazepine medication used to treat seizures and panic disorder.

[5] Promethazine is an antihistamine medication used as a sedative and to treat nausea.

[6] Fentanyl is an extremely powerful opioid medication used to treat severe pain.

Respondent gave B.B. a refill of Percocet and Prochlorperazine,[7] and prescriptions for methamphetamine and hyoscyamine sulfate.[8]

24. On or about July 23, 2014, B.B. saw Respondent for refill of her chronic pain medication. B.B. signed a second pain management agreement. Respondent noted 37 medications in B.B.'s medication list. Respondent documented moderate chronic fatigue arthralgias, daytime somnolence, diarrhea, chronic back pain, chronic joint pain, chronic muscle aches, shoulder pain, and severe right foot pain. Respondent suspected gastroenteritis, and diagnosed osteoarthritis, discogenic disease, Lyme disease, opioid-induced sleep disorder, attention deficit hyperactivity disorder, and hypothyroidism. Respondent prescribed hyoscyamine, Aricept, Fentanyl, Lomotil[9], and methamphetamine. Respondent made a referral to a gastroenterologist, and ordered stool studies. Respondent failed to document an abdominal examination, a back examination, or an examination of the shoulders.

Departures related to B.B.

25. Respondent saw B.B. periodically for follow-up visits over the course of many years. From 2010, until the patient expired in 2014, Respondent never documented a complete history and physical examination regarding the patient's chronic pain. Such a physical examination should have included range of motion and touching the patient to examine for spasm and/or tenderness. Respondent's failure to perform a complete history and physical examination over a period of years constitutes gross negligence.

26. From 2010, until the patient expired in 2014, Respondent failed to document a treatment plan for his opiate prescribing, or objectives of treatment. This failure constitutes gross negligence.

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[7] Prochlorperazine is a highly potent antipsychotic medication, also used for the treatment of nausea, vertigo, and migraine headaches.

[8] Hyoscyamine Sulfate is a medication used to treat muscle cramps in the bowels or bladder, related to irritable bowel syndrome, colitis, and other digestive problems.

[9] Lomotil is a diarrhea medication.

27. From 2010, until the patient expired in 2014, Respondent prescribed a wide variety of medications, in high dosages. During this time, Respondent failed to document any periodic review of his opiate treatment plan, in particular with respect to potential interactions between the many medications the patient was taking. This constitutes gross negligence.

28. Respondent referred B.B. for pain management consultation on two occasions. However, even while the patient was being treated by pain management specialists, she continued to receive opiate medication from Respondent. Respondent failed to coordinate care with the pain management specialists to whom B.B. was referred. Respondent's failure to coordinate care with the specialists to whom he referred B.B. constitutes gross negligence.

29. Respondent failed to document objective findings supporting the need for increased dosages of opiate medication for B.B. This failure represents inadequate recordkeeping and constitutes gross negligence.

Circumstances related to S.H.

30. S.H. was a female patient whom Respondent treated for chronic pain since 2006.

31. On or about June 1, 2011, S.H. presented to Respondent for follow-up regarding her chronic pain. Respondent did not document what body parts were in pain. Respondent failed to document any examination. Respondent prescribed Fentanyl patches and oxycodone. On or about July 6, 2012, Respondent renewed S.H.'s prescription for oxycodone and Fentanyl.

32. On or about June 12, 2014, Respondent documented a diagnosis of back pain and lumbago in S.H. Respondent failed to document any back examination. Respondent prescribed Fentanyl, methadone, methylphenidate[10], and oxycodone

33. On or about September 4, 2015, Respondent documented that S.H. had seen another physician, a pain management specialist who had advised her to stop all of her medications, and to begin treatment with suboxone.[11] Respondent documented diagnoses of lumbago, back pain,

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[10] Methylphenidate (Ritalin) is a medication used to treat attention deficit hyperactivity disorder and narcolepsy.

[11] Suboxone is a medication used to treat opiate dependency.

undifferentiated attention deficit disorder, and ulcerative colitis. Respondent continued the patient's medications without change, including methadone, oxycodone, and promethazine.

34. On or about April 27, 2016, Respondent saw S.H. following hospitalization for a small bowel obstruction. Respondent prescribed clonazepam, promethazine, and oxycodone. Respondent documented a normal abdominal examination. Respondent failed to document any back examination.

Departures related to S.H.

35. During his entire course of treatment of S.H., Respondent never documented a complete history and physical examination. This failure constitutes gross negligence.

36. Respondent made a referral to a pain management specialist for S.H. This physician recommended that S.H. stop all of her medications and begin suboxone treatment. Respondent failed to communicate with the pain management specialist or to follow the specialist's recommendation. Respondent's failure to follow the recommendation of the pain management specialist constitutes gross negligence.

37. The majority of Respondent's notes fail to document a specific body part that was the source of S.H.'s pain, and Respondent failed to assess changes such as increased range of motion or increased strength. These failures represent inadequate recordkeeping and constitutes gross negligence.

Circumstances related to M.H.

38. M.H. was a male patient whom Respondent treated for chronic pain and other issues beginning in 2008, and continuing through 2016. M.H. presented to Respondent on a roughly monthly basis, and Respondent prescribed opiate medication which increased in dosage and strength over time.

39. Beginning in 2011, Respondent prescribed Norco[12] for right shoulder pain. On or about August 31, 2011, M.H. was seen for bilateral shoulder pain. Respondent failed to

[12] Norco is a preparation of acetaminophen and the opioid hydrocodone.

document any physical examination. Respondent injected Kenalog[13] into both shoulders, gave shots of Demerol[14] and promethazine, and refilled the patient's Norco prescription.

40. On or about November 16, 2011, the patient reported that his father had disposed of all of his medications. The patient was given refills of diazepam[15] and Norco, among other medications.

41. On or about December 28, 2011, Respondent increased M.H.'s Norco prescription at the patient's request.

42. On or about January 16, 2012, M.H. was seen for chronic back pain, and reported that his father had again disposed of all of his medications. Respondent failed to document any back examination.

43. On or about February 22, 2012, M.H. presented for perirectal pain and shoulder pain. Respondent documented a rectal examination but no musculoskeletal examination. Respondent was given injections of Demerol and promethazine, and his Norco prescription was refilled. Respondent documented that the patient was taking "too many" of his pain medications.

44. On or about March 21, 2012, M.H. was seen for bilateral shoulder pain. Respondent failed to document a shoulder examination. Respondent gave injections of Demerol and promethazine.

45. On or about April 16, 2012, Respondent documented a plan to "start cutting down" on the patient's Norco intake. Respondent failed to actually reduce the patient's Norco prescription.

46. On or about July 30, 2012, M.H. reported that his medication had been stolen. Respondent provided a refill of the patient's Norco prescription.

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[13] Kenalog is a corticosteroid used to reduce inflammation.

[14] Demerol (meperidine) is an opioid medication used to treat pain.

[15] Diazepam (Valium) is a benzodiazepine medication used to treat anxiety, muscle spasm, and seizures.

47. On or about September 5, 2012, the patient was seen for right shoulder pain, and reported that he had lost his medications while camping. Respondent failed to document any shoulder or back examination, but provided the patient with a refill of his Norco prescription.

48. On or about April 4, 2013, M.H. reported that his mother had thrown away his Norco. Respondent provided a Demerol shot but did not refill the patient's Norco.

49. On or about May 8, 2013, M.H. again reported that his mother had disposed of his Norco. Respondent provided a refill.

50. On or about June 19, 2013, M.H. reported that his medications had been lost. Respondent provided a refill of Norco and clonazepam.

51. On or about July 5, 2013, Respondent was notified by a pharmacy that M.H. had received 2000 Norco tablets in two months.

52. On or about July 15, 2013, M.H. provided a urine drug screen that was negative for narcotics. Respondent failed to discuss the negative urine screen in any note.

53. On or about August 14, 2013, Respondent prescribed Percocet. M.H. reported that Norco was providing no pain relief.

54. On or about September 22, 2013, M.H. reported that his wife had taken some of the Percocet he had previously been prescribed.

55. On or about October 3, 2013, M.H. was seen for bilateral shoulder pain. Respondent failed to document any shoulder or back examination. M.H. was taking 9-10 Percocet tablets per day. Respondent refilled M.H.'s Percocet prescription.

56. On or about November 9, 2014, Respondent saw M.H. for follow-up after hospitalization for narcotic withdrawal. The patient reported that his medication had been stolen.

57. On or about June 29, 2015, M.H. requested early refills because of a trip. Respondent provided early refills.

58. On or about August 3, 2015, M.H. again requested early refills because of an upcoming vacation, and Respondent provided early refills. On or about August 25, 2015, M.H. reported that his medication had been stolen while he was on vacation, and Respondent provided additional refills.

Departures related to M.H.

59. Respondent's notes regarding pain control with opiates lack consistency and rationale. Respondent ignored evidence of diversion, including failed drug screens, consistent early refills, and multiple instances of "lost" or stolen medication. Respondent's failure to act on this evidence constitutes gross negligence.

60. Respondent failed to periodically review the pain treatment he provided to M.H. This failure constitutes gross negligence.

61. Respondent sought consultation from both an orthopedic specialist regarding M.H.'s shoulder pain, and a neurosurgeon regarding M.H.'s cervical spine. However, there is no evidence that Respondent consulted with these specialists regarding the opiate therapy he provided to M.H. Respondent's failure to discuss his opiate treatment of M.H. with the specialists he consulted with constitutes gross negligence.

62. Respondent's notes lacked documentation of objective findings regarding the body part for which opiates were prescribed to M.H. Respondent's failure to document such findings represents inadequate recordkeeping and constitutes gross negligence.

Circumstances related to S.G.

63. S.G. was a female patient whom Respondent treated for chronic pain and other issues beginning in 1989, and continuing through 2014.

64. On or about May 16, 2011, S.G. presented to Respondent for follow-up regarding her fibromyalgia and polyarthralgias. Respondent documented an examination of the neck and spine as well as a neurological evaluation. Respondent continued the patient on a heavy prescription of Oxycontin.[16]

65. Through 2012, and until February 22, 2013, S.G. returned to Respondent for regular follow-ups, and Respondent gradually increased her Oxcycontin prescription, to a peak of 2869 milligram equivalents of morphine per day. On or about February 22, 2013, Respondent began tapering S.G.'s Oxycontin intake. S.G.'s final visit occurred on or about August 27, 2014.

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[16] Oxycontin is a controlled release formulation of the opioid oxycodone.

Departures related to S.G.

66. Respondent failed to document a treatment plan and objectives that would justify the large quantity of opiates he prescribed to S.G. This failure constitutes gross negligence.

67. Respondent failed to document objective findings, including range of motion of the spine and tenderness and spasm, at most of S.G.'s visits. This failure constitutes inadequate recordkeeping and gross negligence.

Circumstances related to W.W.

68. W.W. was a male patient whom Respondent treated for chronic pain beginning in 1999, and continuing through 2016. Between 2011 and 2016 Respondent prescribed Dilaudid[17] and Methadone on a regular basis. Beginning on or about October 10, 2014, Respondent began to slowly taper the patient's opioid intake.

Departures related to W.W.

69. Respondent failed to document any periodic review of W.W.'s opiate treatment. This failure constitutes gross negligence.

70. Respondent failed to seek a pain management consultation for W.W., despite the patient's receiving multiple concurrent opiate prescriptions over a long period of time. This failure constitutes gross negligence.

71. Many of Respondent's notes simply state that the patient was receiving a refill without documenting the source of the pain or any physical examination, such as range of motion or muscle spasm. This constitutes inadequate recordkeeping and gross negligence.

Circumstances related to B.W.

72. B.W. was a male patient whom Respondent treated for chronic pain beginning in 2009, and continuing through 2016.

73. On or about June 15, 2011, B.W. reported that he was "struggling" with chronic pain and depression. Respondent prescribed methadone and Xanax.[18]

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[17] Dilaudid is an opioid medication used to treat moderate to severe pain.

[18] Xanax (alprazolam) is a benzodiazepine used to treat anxiety and panic disorder.

74. On or about August 15, 2011, B.W. presented for follow-up regarding his chronic pain. Respondent failed to document any physical examination. Respondent prescribed Fentanyl and methadone.

75. On or about September 28, 2011, Respondent more than doubled B.W.'s Fentanyl prescription, and additionally prescribed Norco for breakthrough pain. Respondent failed to document any examination, and failed to document the source of B.W.'s pain.

76. On or about October 12, 2011, B.W. again reported that he was struggling with chronic pain. Respondent did not document the source of B.W.'s pain, nor any examination. Respondent prescribed Oxycontin, and again doubled B.W.'s Fentanyl prescription.

77. On or about November 7, 2011, B.W. presented to Respondent following a consultation with a pain management specialist. Based on the specialist's concern regarding the quantity of opioids that B.W. was taking, Respondent reduced B.W.'s Fentanyl prescription.

78. On or about February 8, 2012, B.W. presented to Respondent for low back pain. Respondent failed to document a back examination. Respondent increased B.W.'s Fentanyl prescription, and prescribed Oxycontin.

79. On or about May 24, 2012, B.W. reported that his medications had been stolen. Respondent prescribed Percocet, and reduced B.W.'s Fentanyl prescription by half.

80. On or about June 23, 2012, B.W. was hospitalized for amphetamine and opioid intoxication.

81. On or about August 16, 2012, B.W. presented for chronic back pain and stress. Respondent failed to document any back examination. Respondent prescribed two different Fentanyl patches to be taken simultaneously, as well as methadone. B.W. returned to the Respondent on or about August 22, 2012, reporting that his medication had been stolen.

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82. On or about September 27, 2012, B.W. presented for medication refill for neck and back pain. Respondent failed to document any neck or back examination. Respondent prescribed clonazepam, Dilaudid, oxycodone, methadone, Fentanyl, Soma[19], and Zolpidem.[20]

83. On or about March 13, 2013, B.W. was seen for chronic back pain. Respondent failed to document any back examination. Respondent refilled B.W.'s Fentanyl and methadone prescriptions, and prescribed extended-release morphine.

84. On or about August 14, 2013, B.W. was seen for chronic back pain. Respondent refilled his Fentanyl prescription, and prescribed Percocet.

85. On or about September 23, 2013, B.W. was seen for insomnia and back pain. Respondent failed to document any back examination. Respondent prescribed Fentanyl and trazodone.[21]

86. On or about April 29, 2014, B.W. was hospitalized for altered mental status. A toxicology screen showed positive for opiates, benzodiazepines, methamphetamine, cannabinoids, and MDMA (Ecstasy.)

87. On or about June 6, 2014, B.W. reported that his medications had been stolen. Respondent refilled his Fentanyl prescription.

88. On or about June 30, 2014, B.W. presented to Respondent after a motor vehicle accident that had occurred on May 4. Respondent filled out a DMV form indicating that B.W. was safe to drive a motor vehicle.

89. On or about August 28, 2014, B.W. again reported that his medications had been stolen. Respondent refilled his prescriptions for Valium, Fentanyl, and Norco.

90. On or about June 29, 2015, B.W. again reported that his medications had been stolen.

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[19] Soma (carisprodol) is a muscle relaxant.

[20] Zolpidem (Ambien) is a sedative used to treat insomnia.

[21] Trazodone is an antidepressant with anti-anxiety and sleep-inducing effects.

Departures related to B.W.

91. Respondent failed to document a complete history and physical examination of patient B.W. at any time. This failure constitutes gross negligence.

92. Respondent failed to document a coherent treatment plan for B.W. In particular, Respondent failed to develop a treatment plan following B.W.'s two hospitalizations for overmedication and use of illicit substances. This failure constitutes gross negligence.

93. Respondent failed to periodically review his treatment of B.W.'s chronic pain, particularly in light of B.W.'s two hospitalizations for overmedication and use of illicit substances. This failure constitutes gross negligence.

94. Respondent failed to document any consideration of B.W.'s two hospitalizations for overmedication. This constitutes inadequate recordkeeping and gross negligence.

Circumstances related to M.R.

95. M.R. was a male patient whom Respondent treated for Lyme disease beginning in 1997. Beginning in 2009, Respondent began prescribing Vicodin[22] to M.R. for chronic pain.

96. On or about April 28, 2015, M.R. underwent back surgery to treat his chronic back pain.

97. On or about April 30, 2015, M.R. presented to Respondent. Respondent noted that M.R.'s back pain was improving, but failed to mention the patient's recent surgery. Respondent refilled the patient's hydrocodone prescription without change.

Departures related to M.R.

98. Respondent failed to document any treatment plan or objectives for treatment of M.R.'s chronic pain. This failure constitutes gross negligence.

99. Respondent failed to perform any periodic review of his opiate treatment of M.R. Respondent failed to perform periodic physical examinations of M.R. to measure progress or failure of treatment. These failures constitute gross negligence.

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[22] Vicodin is a preparation of the opioid hydrocodone and acetaminophen.

100. Although M.R. underwent evaluation and treatment by a neurosurgeon, Respondent failed to document any follow-up communication or coordination of care with the neurosurgeon. This lack of follow-up on appropriate consultation constitutes gross negligence.

101. Respondent failed to document any physical examination of the source of M.R.'s pain, such as an examination of the back. This constitutes inadequate recordkeeping and gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

102. Respondent Kurt Eugene Johnson, M.D. is subject to disciplinary action under section 2234, subdivision (c) in that he engaged in repeated acts of negligence. The circumstances are set forth in paragraphs 9 through 101 above, which are incorporated here by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without a Prior Examination and Medical Indication)

103. Respondent Kurt Eugene Johnson, M.D. is subject to disciplinary action under section 2242, in that he prescribed dangerous drugs without an appropriate prior examination and medical indication. The circumstances are set forth in paragraphs 9 through 101 above, which are incorporated here by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Recordkeeping)

104. Respondent Kurt Eugene Johnson, M.D. is subject to disciplinary action under section 2266, in that he kept inadequate medical records. The circumstances are set forth in paragraphs 9 through 101 above, which are incorporated here 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 G 59768, issued to Kurt Eugene Johnson, M.D.;

2. Revoking, suspending or denying approval of Kurt Eugene Johnson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Kurt Eugene Johnson, 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 19, 2017

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

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