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

In the Matter of the Accusation Against:	)	
	)	
MURRAY RICHARD SUSSER, M.D.	)	Case No. 17-2013-229806
	)	
Physician's and Surgeon's Certificate No. G 22316	)	
	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on December 2, 2016.

IT IS SO ORDERED November 4, 2016.

MEDICAL BOARD OF CALIFORNIA

By: Michelle Anne Bholat MD
Michelle Bholat, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MURRAY RICHARD SUSSER, M.D.** **3283 Motor Avenue** **Los Angeles, CA 90034** **Physician's and Surgeon's Certificate No. G 22316** Respondent.	Case No. 17-2013-229806 OAH No. 2016010413 **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 Colleen M. McGurrin, Deputy Attorney General.

2. Respondent MURRAY RICHARD SUSSER, M.D. ("Respondent") is represented in this proceeding by attorney John D. Harwell, Esq., whose address is 225 - 27th Street Manhattan Beach, California 90266.

3. On or about May 2, 1972, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 22316 to Respondent MURRAY RICHARD SUSSER, M.D. The

Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 17-2013-229806, and will expire on September 30, 2016, unless renewed.

4. In a prior disciplinary action entitled *In the Matter of the Accusation Against Murray Richard Susser, M.D.* before the Medical Board of California, in Case Number 17-2002-133925, effective on June 10, 2005, Respondent's license was revoke, however the revocation was stayed and Respondent was placed on five years' probation due to allegations of prescribing a controlled substance for off-label use, which was outside the standard of care. Respondent successfully completed probation on July 30, 2010. That decision is now final and is incorporated by reference as if fully set forth herein.

5. In a prior disciplinary action entitled *In the Matter of the Accusation Against Murray Richard Susser, M.D.* before the Medical Board of California, in Case Number 07-92-16339, effective on May 12, 1997, Respondent's license was revoke, however the revocation was stayed and Respondent was placed on three years' probation due to allegations of quality of care violations involving several patients. Respondent successfully completed probation. That decision is now final and is incorporated by reference as if fully set forth herein.

JURISDICTION

6. Accusation No. 17-2013-229806 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 9, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

7. A copy of Accusation No. 17-2013-229806 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 17-2013-229806. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

9. 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.

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

CULPABILITY

11. Respondent understands and agrees that the charges and allegations in Accusation No. 17-2013-229806, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

12. 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 prima facie factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions to revoke probation or files an Accusation or other disciplinary action against Respondent, all of the charges and allegations contained in Accusation No. 17-2013-229806 shall be deemed true, correct and fully admitted by Respondent only for the purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

14. Respondent further 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:

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CONTINGENCY

15. 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.

16. 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.

17. 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. G 22316 issued to Respondent MURRAY RICHARD SUSSER, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) 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. Additionally, for those Controlled Substances listed in Schedule III of the Act, Respondent shall only be authorized to order, prescribe, dispense, administer, furnish, or possess the following: Adipost, Anadrol-50, Andro LA 200, Andro-Cyp 100, Andro-Cyp 200, Androderm, AndroGel, AndroGel 1.25 g

packets, AndroGel 2.5 g packets, Appecon, Bontril, Deca-Durabolln (nandrolone), Delatest, Depo-Testosterone, Depotest, Durabolin, Durabolin 50, Duratest, Florinal (without codeine only), Hydro-Tussin DHC, Hydro-Tussin EXP, Obezine, Phendiet, Poly-Tussin EX, Poly-Tussin EX syrup, Prelu-2 (phendimetrazine), Prelu-2 TR, Testamone-100, Testim, Testoderm, Testolin, Testro, Testro AQ, Testro-LA, Virilon IM, Winstrol (stanozolol).

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 50 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. 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, will 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 preferably American Board of Medical Specialties (ABMS) certified. 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(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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(s) 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. However, Respondent shall be allowed to continue treating the few patients he currently treats in their residences as long as Respondent had already established a doctor-patient relationship with these patients prior to June 2016, and Respondent shall maintain these patient's medical records in his medical 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, John D. Harwell, Esq.. 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 freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7.5.2016

MURRAY RICHARD SUSSER, M.D.
Respondent

I have read and fully discussed with Respondent MURRAY RICHARD SUSSER, 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: July 5, 2016

JOHN D. HARWELL, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 7/6/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 17-2013-229806

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 9 20 15
BY L. FIRDAUS ANALYST

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

In the Matter of the Accusation Against: **Murray Richard Susser, M.D.** **3283 Motor Avenue** **Los Angeles, CA 90034** **Physician's and Surgeon's Certificate No. G 22316,** Respondent.	Case No. 17-2013-229806 **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 May 2, 1972, the Medical Board issued Physician's and Surgeon's Certificate Number G 22316 to Murray Richard Susser, 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 September 30, 2016, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

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

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

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

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, 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 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."

7. Subdivision (a) of section 2242, of the Code states: APrescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in connection with his treatment of patients. The circumstances are as follows:

Patient B.T.

9. Respondent first saw B.T.,[1] a 31-year-old woman, on or about January 6, 2011, who presented to him with complaints, including,[2] bulging discs in her cervical and thoracic spine and severe chronic pain in her neck and upper back. She had been in pain for approximately five to six months. On her intake sheet, B.T. indicated that a chiropractor referred her to Respondent. B.T. also indicated that she was taking Paxil,[3] Vicodin[4] and ibuprofen, as well as vitamins and fillers. Respondent noted that B.T. might have osteoarthritis of the spine with no history of trauma. Respondent also wrote that B.T. might "have allergy to vitamin preps," and that she was "taking Vicodin for excruciating pain; gets nausea and vomiting." In addition, Respondent wrote that B.T. was not suicidal, but in continuous pain and not sleeping well because of exhaustion from her pain. Respondent also wrote, "stem cells?" Respondent documented that the patient said, "I've seen everyone, neurologists, etc, not much help." During his initial visit with B.T., Respondent failed to perform or document an adequate physical exam (other than the patient's vital signs), and failed to obtain an adequate history for her, including her social history. Respondent also failed to provide an assessment or diagnosis. Respondent's plan was to "discuss Percodan #100; sig 1 q8 hrs prn." Respondent also planned to perform a "chem panl, vitamin D level" and "iodine serum."

On or about January 6, 2011 [A59 p.119], Respondent prescribed to B.T., 100 tablets of 5

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[1] Patients' initials are referred hereto to protect their privacy.

[2] As used herein, the word "including" shall mean including, "but not limited to."

[3] A selective serotonin reuptake inhibitor antidepressant is a dangerous drug used to treat depression, obsessive-compulsive disorder and anxiety.

[4] Vicodin is a brand name for a narcotic pain medication consisting of a combination of hydrocodone and acetaminophen. It is a schedule II controlled substance under Health and Safety Code section 11055, subdivision (b) (1)(I).

mg Oxycodone,[5] and 100 tablets of 25 mg Phenergan[6].

10. On or about January 27, 2011, Respondent documented a telephone call with B.T. His note is largely illegible, however following this call, Respondent prescribed to B.T., 100 tablets of 10/500 Lortab[7] with one refill. B.T. also refilled this Lortab prescription on or about February 15, 2011.

11. On or about March 6, 2012, Respondent documented that while B.T.'s neck was "now all better after steroid facet injections," she developed a squamous cell. He also noted that:

> "[She] Now has spasm. Has lymph edema from the radiation. Treated by [another physician] with high dose of oxycodone (30 mg) from Horton and Converse. She is not receiving any meds now because [the other physician] is retiring due to illness. Patient has not had a follow-up MRI."

The record also reflects that Respondent "discussed use of large dose narcotics" and that getting medications "seems to help." The form on which the note of March 6, 2012, was written includes a physical exam section, and pre-printed letters "HEENT" are circled. No vital signs are recorded. Abnormal findings consist of a drawing that appears to indicate the patient's right neck, with a partially illegible note that includes words "exquisite tenderness with barely a brush of finger. Possible allergy to Vit E [illegible]." Assessment included illegible notes, as well as "severe radiation neuropathy" and "advise Phenergan try for [illegible]." Respondent's plan included a follow-up MRI and a prescription for 180 tablets of 30 mg oxycodone every four hours as needed for pain. This note is not signed.

12. Respondent's medical records for B.T. also include a letter from the patient dated March 6, 2012, wherein she asserted that Respondent and another doctor diagnosed her with intractable pain at a level of ten out of ten, and that she is unable to function without large doses of oxycodone. The patient also asserted that she will not be receiving pain medication from "any

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[5] Oxycodone is a narcotic pain medication. It is a schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M).

[6] Phenergan is a brand name for promethazine, an anti-nausea medication.

[7] Lortab is a brand name for a combination of hydrocodone with acetaminophen. It is a schedule II controlled substance under Health and Safety Code 11055, subd. (b)(1)(I)

other doctor." She indicates that Respondent is taking over her care from the other doctor who is retiring.

13. On or about March 6, 2012, Respondent prescribed 180 pills of oxycodone, 30 mg. to B.T., to be taken every four hours as needed for pain.

14. On or about March 29, 2012, Respondent noted in the subjective portion of the note : "pain is unchanged. Still doing PT." The next sentence on the note is illegible. The note is unsigned and the portions of the form dealing with objective observations, assessment and plan are blank.

15. On or about March 29, 2012, Respondent prescribed to B.T. (a) 180 tablets of 30 mg oxycodone, which the patient filled on or about that date at Horton and Converse pharmacy; and (b) 100 tablets of 10/500 Lortab which the patient filled on or about April 6, 2012, at the Rite Aid Pharmacy. The Lortab prescription was refilled with Respondent's approval on May 8, 2012, May 31, 2012, and June 20, 2012.

16. Respondent's next note is dated August 12, 2012, and includes no physical exam or assessment. It states "pain now worse – still dealing with pain" and discusses a Cymbalta prescription by the patient's prior physician.

17. Respondent continued to see B.T. through April 2014. During that time, Respondent's progress notes for B.T. were frequently very short and failed to include physical exam or assessment sections. Although several notes are indicated as phone records, it cannot be determined whether certain other entries are in person office visits or phone notes. Many entries briefly mention the presence of and/or slight change in B.T.'s pain.

18. Respondent's progress notes for 2013 were short and did not include much detail.

(a) A note dated March 14, 2013, states that B.T. is trying to wean from using oxycodone.

(b) A note dated June 10, 2013, states the patient still has some "radicular intractable pain." Several notes comment on renewing prescriptions for controlled substances.

(c) A notation dated August 21, 2013, includes the statement "discuss pain &

ketamine coma." There is no notation regarding the prescribing of opioids for that date.

(d) A note dated September 3, 2013, is one line and completely illegible.

(e) A note dated October 28, 2013, includes vital signs and one line saying, "pain is the same. Still needs Effexor." There is also a noted Rx for Phenergan and vicoprofen but without doses or amounts.

(f) A note dated November 19, 2013, is labeled a phone refill on oxycodone with the only other notation "intractable pain."

(g) A note dated December 10, 2013, stated only "refill vicodin 10/500."

(h) A note dated December 12, 2013, states:

"thyroid under control- continue T4; pain unchanged. Still intractable; Medication are the only way she can cope with intractable pain. Without meds she might be suicidal."

No other physical exams, assessments or plans are noted.

19. Respondent's first three notes for B.T. in 2014 (i.e., dated January 6, February 3 and March 3, 2014) were about three to four lines long each and failed to include any physical exam, assessment, or clear plan. And the next note, dated March 24, 2014, was only one line stating, "pain the same. Refill vicoprofen 7.5."

20. Although Respondent's progress note, dated March 31, 2014, includes vital signs, no other physical exam is documented. Further, the note stated "can't get pain relief with oxycontin; has 5 mm disc protrusion; (illegible) tachyphylaxis; not seeing any other pain doctor; unbearable pain- intractable." And, a quote stated, "I'll have to try street drugs. I'm not gonna live with this pain." The note also indicated that the "[patient] is terrified of the pain; the [illegible] will not [illegible] adequate pain Rx; schedule another follow-up PE & blood draw; pain is always at least a 7/10." There is no assessment section. The plan states "will try smaller doses; [illegible] panel; will try fentanyl patch 75 meg patches q3 days."

21. Although the note dated April 14, 2014, includes vital signs, no other physical examination is documented. The note also stated that "pain is still the same; nobody has found a

solution; she has found a new traction Rx which looks promising- some loosening of neck; pt has found a pharmacy who might be willing to fill Rx; she phoned 75 pharmacies before she found a pharmacy; fentanyl helps give some relief; pt is having trouble getting Rx filled." There is no assessment or plan section documented.

22. The seven remaining subsequent notes after April 2014 for B.T. are all very brief and all but two state that they are phone entries. Four of these specifically mention refills for a controlled substance. The note dated June 26, 2014, reads: "phone; needs refill of pain." The note dated August 19, 2014, which is the final note in Respondent's records, reads: "phone - pt needs more pain relief than this but the law is keeping her from getting appropriate Rx; [illegible] policy at Walgreens worried about."

23. Respondent's medical records for B.T. are devoid of any clear treatment plan with objectives despite documentation on or about October 28, 2013, that B.T. had taken anti-depressant medication (Effexor)[8] and had an appointment with an osteo clinic on or about February 3, 2014. During the time Respondent treated B.T., she had been receiving prescriptions for dangerous drugs from other providers as well. Respondent frequently prescribed opioids to B.T. during his treatment of her, including in 2012, 2013, and 2014. However, Respondent failed to document any clear improvement in the patient's pain or function that was achieved by the use of controlled substances. During the period from February 2013 through February 2014, the patient filled an average of several hundred opioid tablets a month that were prescribed by Respondent. Moreover, potential problems were indicated in the record, including threats of suicide and obtaining drugs from the street. However, Respondent failed to consider or consult with a pain management or psychiatric expert or change his treatment approach.

24. Each of the following acts or omissions by Respondent represents gross negligence:

A. Respondent's failure to adequately perform or document (including indications for any drug treatment) his physical examination of B.T. or taking her history, including, in

[8] A prescription drug used to treat depression, generalized anxiety disorder (GAD), panic disorder, and social anxiety disorder. This medicine is a serotonin and norepinephrine reuptake inhibitor (SNRI).

connection with her initial evaluation or prior to his initiation of narcotic treatment.

B. Respondent's failure to perform adequate periodic review of his course of treatment for B.T., including, adequate examinations or assessments, or referrals or consultations with additional experts in light of the patient's ongoing pain (and lack of documented consistent improvement) and narcotic treatment.

Patient M.B.

25. Respondent Murray Richard Susser, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in his treatment of patient M.B. The circumstances are as follows:

26. On or about January 17, 2012, Respondent first saw patient M.B., a 70-year old woman, with a vague complaint stating, "I am deteriorating." M.B. did not provide a completed patient information questionnaire; she only completed the identifying information portion of the form. M.B. had a history of irritable bowel syndrome (since age 30), depression, insomnia, migraine and pain. M.B. was taking Bentyl, and had tried Celexa, Prozac, Lexapro and homeopathic cures. M.B. allegedly had previous diagnostic tests. There are notations indicating certain normal findings from a physical exam, although portions of the writing are not legible. There is a "2+" on either side of the neck on a hand-drawn figure in the chart. M.B. described her pain as always "intolerable." However, the severity, quality, location or duration of the pain is not documented. M.B. purportedly became depressed at age 20 when her mother passed away. M.B.'s mother had a cerebral aneurysm. There is no assessment or plan documented.

27. On or about January 18, 2012, M.B. returned to Respondent and indicated she had pelvic pain that she had not mentioned the previous day. According to the note, she had two ultrasounds which Respondent noted were clear. Respondent wrote that M.B. had diverticulosis since age 28. The physical exam form had the preprinted words abdomen and rectal circled. The assessment section stated: "1) Pelvic ligament strain, 2) Needs Percocet - feels better, 3) [illegible]." On that date Respondent prescribed Carafate, Xanax, Norco and Percocet to M.B. M.B. was also referred to a chiropractor, F.C.

28. On or about August 28, 2012, Respondent saw M.B. and wrote that the patient was

still taking Vicodin and Xanax, but Cymbalta and Prestiq did not work. M.B. apparently still had migraines and pain in her pelvis. Her best friend recently died. M.B. reported that she cried all the time and had no family since her son is leaving to go back to California. The assessment section stated that Xanax was the only drug that helped her sleep and the plan section stated that Respondent would refill her Xanax and Norco.

29. On or about September 18, 2012, M.B. returned to Respondent and indicated that she was severely stressed and had to take additional medication. Her son has disappointed her and left her alone. Respondent refilled her Xanax 2 mg (100 tablets) q.4 hours p.r.n. with 3 refills.

30. On or about November 13, 2012, Respondent saw M.B., who had anxiety, depression and was crying all the time. She indicated that she had tried multiple antidepressants, and stated, "I need to go into [rehabilitation.]" M.B. also noted that she was going to a gastrointestinal specialist. She also needed a partial refill because she told Respondent that she left her Xanax in Portland.

31. On or about November 21, 2012, M.B. called and indicated that she had lost her prescription in the mail and needed a refill. M.B. was given an emergency refill until she "finds" her misplaced medications. However, there was no documentation regarding what prescription was refilled.

32. There is a very brief note dated March 1, 2013 stating, "L/M take one hour between meds; Xanax, ultram, norco."

33. On or about March 7, 2013, Respondent saw M.B. with complaints of severe migraine. Respondent wrote that the Vicodin helps with the migraine pain, and that she uses the pain pills carefully. He prescribed Ultram to her.

34. There is a phone note dated on or about April 5, 2013, reflecting that Respondent's office received an anonymous call stating that M.B. "does not want to live anymore." A phone number is listed as well. The note that follows says, "I am not planning suicide." Her pills were apparently not working very well, and she was in detox but left against medical advice because she did not want to be in a locked facility. Respondent's assessment was that M.B. was "severely depressed as usual, but no suicidal ideation at this point."

35. There is a phone note dated on or about April 28, 2013, indicating that M.B. fell and received the wrong pills. Respondent instructed her that he could not help her and that she needed to get a local doctor to deal with the emergency.

36. There is a note dated on or about May 1, 2013. M.B. indicated that she fell in the bathroom 10 days prior, and reported, "I am going to die if I do not get my meds." Respondent refilled her prescription for Xanax. Respondent also prescribed Norco to her.

37. On or about July 1, 2013, Respondent saw M.B. Her vital signs were normal, but she apparently looked pale and drawn. She cried spontaneously. Respondent wrote that M.B. "has no suicidal ideation. She has strong will to live despite intractable pain and depression."

38. On or about January 8, 2014, Respondent saw M.B. She had lost 30 pounds because of her irritable bowel syndrome, and continued to have pain from her previous femur fracture. Respondent prescribed to her Dilaudid, Xanax and Colace. M.B. was also given an injection of B vitamins.

39. On or about January 9, 2014, M.B. was sent home after offending a nurse and other patients in Respondent's IV room.

40. On or about January 15, 2014, M.B. had an EKG performed on her for palpitations. Blood pressure and heart rate were normal. Her EKG was interpreted as normal. No other history or examination was recorded.

41. On or about March 17, 2014, M.B. was evaluated by an orthopedist.

42. On or about March 20, 2014, Respondent prescribed to M.B., Xanax and Phenergan. The note indicated that M.B. was living in assisted living and that morphine was not working. There was a phone call from the pharmacist.

43. On or about March 20, 2014, M.B. signed agreement indicating that she would only receive her narcotics from Respondent (and to notify him if she was seeing any other doctor for narcotics).

44. On or about May 1, 2014, M.B. was evaluated by an orthopedic surgeon who concluded that her pain levels were quite severe and uncontrollable. He referred her to a UCLA pain management specialist.

45. A note in Respondent's record dated on or about July 22, 2014, indicated that M.B. was being thrown out of her son's house. Her pain was described as unbearable.

46. A note in Respondent's records dated on or about August 20, 2014, is not legible.

47. On or about September 1, 2014, Respondent's note indicated that M.B.'s son had left town. She was out of Norco, and the plan included a fentanyl patch trial.

48. A note dated on or about September 17, 2014, is mostly illegible and indicates talking to her son.

49. On or about September 17, 2014, adult protective services was notified due to M.B.'s poor caloric intake.

50. In a note dated on or about July 26, 2014, or on or about September 26, 2014 (there are two dates, one on the top left hand of the page and another on the top right hand of the page), Respondent documented that M.B. indicated that she was going to St. John's for an orthopedic evaluation. According to this note she had been diagnosed with reflex sympathetic dystrophy or complex regional pain syndrome. Percocet, Norco and Xanax were prescribed by Respondent. A verbal order was also given for Toradol. The note, stated, "I cannot help her."

51. Respondent's medical record contains an undated handwritten letter from M.B. indicating that she was in severe pain and included a request for inpatient treatment.

52. There are records in Respondent's chart for M.B., from other providers, including, one dated January 4, 2012 from OHSU, and a psychiatric evaluation documenting depression and/or bipolar disorder, and overmedication, including abuse of Alprazolam,[9] and advising psychotherapy. These records reflect that another provider confronted M.B. about doctor-shopping, i.e., violating the pain contract by obtaining narcotics from multiple providers.

53. Most of the progress notes in Respondent's records for M.B. are handwritten, but not signed and several are partially or completely illegible.

54. Each of the following acts or omissions by Respondent represents gross negligence:

[9] Alprazolam, also known as Xanax, is a short-acting anxiolytic of the benzodiazepine class. It is commonly used for the treatment of panic disorder, and anxiety disorders, such as generalized anxiety disorder and is a Schedule IV Controlled Substance (Health and Safety Code section 11057, subdivision (d)(1).)

A. Respondent's failure to perform adequate periodic review of his course of treatment for M.B., including, adequate examinations or assessments, or referrals or consultations with additional experts in light of the patient's ongoing pain and narcotic treatment and given the red flags, e.g., psychiatric instability, lost prescriptions, filling prescriptions out-of-state, history of drug misuse and admission for need of rehabilitation.

B. Respondent's failure to consider or seek appropriate consultation with a psychiatric or pain management expert in light of M.B.'s condition, including, her psychiatric issues, and/or ongoing treatment with narcotics.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated acts of negligence in treatment of patients B.T. and M.B. The circumstances are as set forth in the allegations of the First Cause for Discipline, which are incorporated herein by reference as if fully set forth, and represent repeated negligent acts. In addition, the following acts of negligence are alleged:

Patient B.T.

56. Each of the following acts or omissions by Respondent represents negligence:

A. Respondent's failure to adequately perform or document a clear treatment plan with objectives in light of B.T.'s complicated pain syndrome and psychiatric issues.

B. Respondent's failure to adequately perform or document an informed consent for B.T. including a discussion of the risks and benefits of the use of controlled substances, including the patient's use of opioids and history of drug use, e.g., Suboxone in 2011.

C. Respondent's failure to adequately perform or document adequate consultation with, or referrals to, additional healthcare expert treatment providers in connection with his care for B.T., including psychiatric and pain management experts and neurologists, especially in light of the patient's complex pain and psychiatric issues.

D. Respondent's failure to adequately or accurately document his care and treatment for B.T., including a history and physical examination, other evaluations and

consultations, if any, treatment plans and objectives, informed consent, prescribed medications and indications (and rationales for changes), and periodic review.

Patient M.B.

57. Each of the following acts or omissions by Respondent represents negligence:

A. Respondent's failure to adequately perform or document (including indications for any drug treatment) his physical examination of M.B. or taking her history, including, in connection with her initial evaluation (when Respondent failed to adequately perform an assessment, or formulate a clear treatment plan) or prior to his initiation of narcotic treatment.

B. Respondent's failure to adequately perform or document an informed consent for M.B., including a discussion of the risks and benefits of the use of controlled substances especially in light of the patient's history of drug use and psychiatric issues.

C. Respondent's failure to adequately or accurately document his care and treatment for M.B., including a history and examination, other evaluations and consultations, if any, treatment plans and objectives, informed consent, prescribed medications and indications (and rationales for changes), and periodic review.

THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

58. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate or complete medical records of his care and treatment for each of his patients B.T. and M.B. The circumstances are as set forth in the allegations of the First and Second Causes for Discipline, which are incorporated herein by reference as if fully set forth. In addition, the written medical records Respondent prepared in connection with patients B.T. and M.B. are frequently illegible.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Prior Examination/Indication)

59. Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code in that he prescribed, dispensed, or furnished dangerous drugs as defined in Code section

4022 without an appropriate prior examination and/or a medical indication. The circumstances are as set forth in the allegations of the First and Second Causes for Discipline which are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

60. Respondent is subject to disciplinary action under section 2234 of the Code, generally, in that he committed unprofessional conduct. The circumstances are as set forth in the allegations of the First through Fourth Causes for Discipline inclusive, which are incorporated herein by reference as if fully set forth.

DISCIPLINE CONSIDERATIONS

61. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that Respondent has a history of unprofessional conduct.

62. Complainant alleges that on or about June 10, 2005, in a prior disciplinary action entitled In the Matter of the Accusation Against Murray Richard Susser, M.D. before the Medical Board of California, in Case Number 17-2002-133925, Respondent's license was revoked, but the revocation was stayed and Respondent was placed on five years' probation due to alleged prescribing outside of the standard of care. In addition to the standard terms and conditions of probation, Respondent's controlled substance prescribing privileges were limited to Schedule IV and V substances, Respondent was required to maintain controlled substance records, take a prescribing practices course, complete the PACE Program and install a practice and a billing monitor. Respondent completed probation on or about June 10, 2010. That decision is now final and is incorporated by reference as if fully set forth herein.

63. Complainant alleges that on or about May 12, 1997, in a prior disciplinary action entitled In the Matter of the Accusation Against Murray Richard Susser, M.D. before the Medical Board of California, in Case Number 07-92-16339, Respondent's license was revoked, but the revocation was stayed and Respondent was placed on three years' probation due to allegations of quality of care violations involving several patients. Respondent completed probation. That decision is now final and is incorporated by reference as if fully set forth herein.

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 22316, issued to Murray Richard Susser, M.D.;

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

3. Ordering Murray Richard Susser, 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: December 9, 2015

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

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