CURRICULUM VITAE:
06/01/2014
Rick Chavez, M.D.
DEA license
California Medical License

BOARD CERTIFICATION

- **BOARD CERTIFIED, AMERICAN BOARD OF PAIN MEDICINE**
- **BOARD CERTIFIED, AMERICAN BOARD OF FAMILY PRACTICE**
- **BOARD CERTIFIED, AMERICAN BOARD OF ADDICTION MEDICINE**
- **DIPLOMATE OF AMERICAN ACADEMY OF PAIN MANAGEMENT**

POSTGRADUATE TRAINING

- **HARBOR-UCLA/SPPH JOINT FAMILY PRACTICE RESIDENCY**
  1979-1982

MEDICAL SCHOOL

- **UCLA DAVID GEFFEN SCHOOL OF MEDICINE**
  Degree: M.D.
  1975-1979

UNDERGRADUATE

- **STANFORD UNIVERSITY**
  Degree: BA- PSYCHOLOGY
  1971-1975

CURRENT HOSPITAL APPOINTMENTS

- **LITTLE COMPANY OF MARY HOSPITAL AND MEDICAL CENTER**
- **TORRANCE MEMORIAL HOSPITAL**

FACULTY APPOINTMENTS

- **ASSISTANT CLINICAL PROFESSOR OF FAMILY MEDICINE**
  UCLA DAVID GEFFEN SCHOOL OF MEDICINE 1992-7/2011

- **CLINICAL FACULTY, USC SCHOOL OF MEDICINE**
  DEPARTMENT OF FAMILY MEDICINE 1987-1992

- **CLINICAL INSTRUCTOR, USC SCHOOL OF MEDICINE**
  PHYSICIAN ASSISTANT TRAINING PROGRAM 1993-1996

- **CLINICAL INSTRUCTOR, AHEC/HISMET**
  UC DAVIS SCHOOL OF MEDICINE 1989-1991

- **CLINICAL INSTRUCTOR, HARBOR-UCLA/SPPH**
  FAMILY PRACTICE RESIDENCY PROGRAM 1982-1987

MEDICAL DIRECTORSHIPS

- **MEDICAL DIRECTOR, HEALTHCARE RESOURCE GROUP**
  SOFTWARE DEVELOPMENT AND INFORMATION SYSTEMS
  2001-CURRENT

- **MEDICAL DIRECTOR AND FOUNDER, THE PAIN INSTITUTE, MEDICAL INSTITUTE OF LITTLE COMPANY OF MARY HOSPITAL, TORRANCE CA**
  2003-2005

- **MEDICAL DIRECTOR, UNIVERSAL INTEGRATED HEALTH MEDICAL GROUP AND CREST SURGI CENTER, NEWPORT BEACH, CA 2005-2006**

- **MEDICAL DIRECTOR, AMBULATORY CARE SERVICES**
  HEALTHCARE PARTNERS MEDICAL GROUP,
  REGION III
  2000-FEBRUARY, 2003

- **MEDICAL DIRECTOR, CARSON CARE STATION**
  MEDICAL ASSOCIATES OF LITTLE COMPANY OF MARY
  1998-2002

- **MEDICAL DIRECTOR, CEO AND FOUNDER**
  COASTAL PHYSICIANS MEDICAL GROUP
  1982-1998

- **VICE PRESIDENT AND CO-FOUNDER**
  ALLIANCE OF PRIVATE PRACTICE PHYSICIANS IPA
  1986-1997

- **MEDICAL DIRECTOR,**
  CHRONIC MULTIDISCIPLINARY PAIN CENTER
  SAN PEDRO AND PENINSULA HOSPITAL **1984-1988**

- **MEDICAL DIRECTOR,**
  CHRONIC MULTIDISCIPLINARY PAIN CENTER
  BAY HARBOR HOSPITAL **1988-1989**

- **MEDICAL DIRECTOR,**
  TODD PACIFIC SHIPYARDS OCCUPATIONAL CLINIC **1982-1987**

PROFESSIONAL CONSULTANT

DRUG ENFORCEMENT AGENCY: EXPERT WITNESS, CURRENT
MEDICAL BOARD OF CALIFORNIA: EXPERT WITNESS, CURRENT
FOREST LABORATORIES, CURRENT
ENDO PHARMACUETICALS, CURRENT
RECKITT BENCKISER, CURRENT
CEPHALON PHARMACUETICALS, CURRENT

PREVIOUS EMPLOYMENT AND CONSULTING

- **CONSULTANT, QC LABORATORIES/April 2002**
- **MEDICAL CONSULTANT/EXPERT WITNESS**

- **TUVERSON & HILLYARD LAW FIRM/DOCTORS COMPANY/1996-2000**
- **INTRACORP UTILIZATION REVIEW:PHYSICIAN CONSULTANT/1984-1992**

PROFESSIONAL SOCIETIES

- **AMERICAN MEDICAL ASSOCIATION**
- **LOS ANGELES COUNTY MEDICAL ASSOCIATION**
- **AMERICAN ACADEMY OF PAIN MANAGEMENT**
- **THE SOCIETY FOR PAIN MANAGEMENT**
- **AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS**
- **AMERICAN PAIN SOCIETY**
- **AMERICAN ACADEMY OF ADDICTION PSYCHIATRY**

PROFESSIONAL LICENSURE

- **AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)**
- **CALIFORNIA STATE PHYSICIANS AND SURGEONS LICENSE**
- **DRUG ENFORCEMENT AGENCY LICENSE**
- **CERTIFIED TO USE BUPRENORPHINE IN OPIATE ADDICTED PATIENTS. PHYSICIAN WAIVER #2799 AT SAMHSA STATE OF CA**

AWARDS AND COMMITTEES

- **"ABUSE, ADDICTION, AND PAIN RELIEF: TIME FOR A CHANGE": EXPERT FACULTY MEMBER INVITED TO PARTICIPATE IN A ROUND TABLE SUMMIT IN BETHSEDA, MARYLAND; CO-SPONSORED BY NIDA, NATIONAL INSTITUTE OF DRUG ABUSE; AMERICAN PAIN FOUNDATION; AMERICAN PAIN SOCIETY. 2008**

- **2005 BUPRENORPHINE SUMMIT CONFERENCE, MARYLAND SAMHSA, CSAT & DEPT. OF HEALTH & HUMAN SERVICES**

- **BOARD MEMBER, MEDICAL ASSOCIATES OF LITTLE COMPANY OF MARY HOSPITAL & MEDICAL CENTER/ 1999-2002**
- **CHAIRMAN, DEPARTMENT OF FAMILY MEDICINE SAN PEDRO PENINSULA HOSPITAL 1984-1987**
- **BOARD MEMBER, EXECUTIVE COMMITTEE SAN PEDRO PENINSULA HOSPITAL 1984-1987**

- **TRUSTEE, SAN PEDRO AND PENINSULA HOSPITAL/ 1982-1983**
- **CHAIRMAN, HOSPITAL GEOGRAPHIC OUTREACH COMMITTEE SAN PEDRO PENINSULA HOSPITAL / 1995**
- **MEMBER OF CONGRESSWOMAN JANE HARMON'S HEALTH CARE TASK FORCE / 1994**
- **PARKE-DAVIS TEACHER DEVELOPMENT AWARD / 1982-1983**

- **MEMBER OF UTILIZATION REVIEW, MICU, SURGERY, NUTRITION, FAMILY PRACTICE RESIDENCY, REHABILITATION, IPA UTILIZATION, & MARKETING ADVISORY COMMITTEES SAN PEDRO PENINSULA HOSPITAL / 1982-1994**

<u>MEMBER OF PHYSICIAN WELLNESS COMMITTEES:</u>

LITTLE COMPANY OF MARY HOSPITAL- 2003-CURRENT
TORRANCE MEMORIAL MEDICAL CNTR- 2003-CURRENT
MEDICAL ADVISOR ON THE BOARD OF PAIN.COM

PUBLICATIONS

"ABUSE, ADDICTION, AND PAIN RELIEF: TIME FOR A CHANGE."
CLINICIAN CME PROGRAM, September, 2008; content presented in this CME Newsletter was derived from the roundtable discussion held in Bethesda, Maryland, February 2008.

SOUTHBAY HEALTH PUBLICATION Jan/Feb 2005
Article by David Hunt, Publisher and Editor.
"Revolutionizing the Treatment of Pain"

TELEVISION & RADIO & VIDEO

Appeared on "A Las Cuatro" Channel 22 (Televisa/NBC) as Medical Director of The Pain Institute at Little Company of Mary -Discussed Opiate Addiction and Chronic Pain. 10/01/03.

Appeared on KCAL 9 News at 2 P.M. and 8 P.M. on 10/02/03 And 10/03/03 Health Segments to discuss Buprenorphine Treatment in Chronic Pain Patients addicted to Opiate Analgesics.

SENIOR LIVING, Program #37, Nov. 30, 2004
"Nutrition Solutions For Seniors"
Community Television Channel
Host: Lynn Brennan

Previously, Dr. Chavez was Medical Director of The **Chronic Pain Center** at San Pedro & Peninsula Hospital for 5 years; Medical Director of **Todd-Pacific Shipyards Occupational Health Clinic** for 5 years; Chairman of the **Department of Family Medicine at San Pedro Peninsula Hospital** for 3 years; Medical Director, CEO, & Founder of Harbor Family Medical Group & **Coastal Physicians Medical Group**; Co-founder of **Alliance of Private Practice Physicians** IPA; Medical Director of the **Carson Care Station** at Little Company of Mary for 4 years, and Board Member of the Medical Associates of Little Company of Mary Hospital for 2 years.

30 YEARS OF CLINICAL EXPERIENCE

I practiced primary care medicine for the first 20 years of my practice, and in addition I added my expertise in Pain and Addiction medicine to my practice over the last last 10 years. I honestly believe that few physicians have had the breadth of experience in medicine that I have achieved. I am quite proud of my level of medical expertise and when I speak to a patient about a hip replacement or a hysterectomy, I have actually first assisted in over 150 hip and knee replacements and 100 hysterectomies over the last 30

years so my knowledge and reassurance about these procedures, the potential complications, and the pre and post op care required is accurate. The same is true in treating painful disorders. I have treated almost every kind of acute and chronic pain disorder during my career and I know when someone is in need of immediate resolution of their pain or other clinical problems, so I make it my priority to be there to comfort and care for them as soon as possible, often saving them a trip to urgent care or the emergency room. Elderly patients, especially those who suffer with dementia need medical expertise and relief of pain and suffering immediately. Their quality of life is of utmost importance, so preventing an unneeded emergency room trip or handling their urgent situation rapidly and accurately can mean so much to the geriatric patient and their families as well as to to the staff of the center.

Primary care medicine: newborn care, well child care, geriatric care, internal medicine, gynecology, occupational medicine, orthopedics, neurology, cardiology, urgent care, chemical dependency and chronic pain management.

Experience with Practice Partner Electronic Medical Record System, HealthFusion EMR, extensive experience with Dragon Speak Medical Auto-Dictation System, Meditech, Versyss, and PAX radiology system.

After 30 years of clinical experience in medical practice and teaching young doctors in training there is very little that Dr. CHAVEZ has not experienced or seen. Procedures include: minor trauma and laceration care, excisional biopsies of skin neoplasms, Norplant implantation, sigmoidoscopies, applying casts and splints for uncomplicated fractures and ligamentous injuries, trigger point and joint injections of the hip, knee, wrist, fingers, ankle, elbow, shoulder, cervical spine, scapula, deltoid, Acromio-Clavicular joint, TMJ, toes, groin, facet blocks, culdocentesis, lumbar puncture, plantar wart therapy, ganglion and sebaceous cyst removal and aspiration, abscess Incision and Drainage, Ingrown toenail removal, ear lavage, bladder cath, corneal abrasion recognition and treatment, nasopharyngeal cautery of bleeding, cryotherapy, Nerve blocks include greater and lesser occipital nerves, Femoral Nerve, Abdominal Wall/Rectus Abdominis Nerves, Costochondral, and many more Nerves. Experience with botox injections, Tendon and bursa injections, Schiotz tonometry, venous cutdowns, neonatal circumcision, Synvisc injection to the knee, Blind thoracic, lumbar, and sacral Facet Blocks, Dermabrasion, and indirect laryngoscopy.

Extensive Experience reading routine X-rays and Electrocardiograms. Experience with Auricular Acupuncture.

Hospital care includes: UnrestrictedAdmission privileges to all medical and surgical floors, telemetry, nursery, intensive care units, Pediatrics, Psychiatry, Chemical Dependency Units, Step Down Units, SNF, and Rehabilitation at Torrance Memorial Medical Center and Little Company of Mary Medical Center.

<u>SURGICAL ASSISTING EXPERIENCE</u>
Extensive surgical assisting experience: First Assistant in the following procedures:

Appendectomy, Open Cholecystectomy, Herniorraphy, Total Abdominal and Partial Vaginal Hysterectomy, Pelvic Laparoscopy, Radical Prostatectomy, Mastectomy, Partial Colon and Small Intestine Resections, Partial Gastrectomies, Vagotomy and Pyloroplasty, Hiatel Hernia Repair, Aortic Aneurysm Resection, Aorto-Bifem Bypass, Splenectomy, Nephrectomy, Bladder Suspension and Repair, Adrenal Gland Resection, Thyroidectomy, Parathyroidectomy, Radical Neck Dissection, Elbow/Shoulder/Wrist Fracture Repair and Nerve Decompression, Total Knee replacement, Shoulder and Hip Replacement and Arthoplasty, AC Joint Repair, Knee Arthroscopy, Lumbar Laminectomy and Diskectomy, Bunion and Hammertoe Repair, AV Shunt Creation, Vein stripping, Hemorroidectomy, Extremity Amputation, Carotid Artery Endarterectomy, Cesarean Section, Laparoscopic Cholecystectomy, Tubal Ligation, Breast Prosthesis Implants, Penile Implants, Orchiectomy, Skin Grafting, Acute Trauma Surgery, and Vasectomy, Newborn circumcision. Wound and Burn care.

Previous Obstetrical experience, during his residency, includes over 250+ normal vaginal deliveries and experience with use of vacuum and forceps. Also, 37 cesarean sections while serving as supervising resident on OB for 3 months at Harbor General/UCLA Medical Center. In addition, he has served as Clinical Faculty at various times with the USC School of Medicine and UC Davis School of Medicine.

ABSTRACTS:

Buprenorphine Treatment as an Alternative to Orthopedic Surgery in Patients on Prescription Opiates with Lumbosacral or Cervical Spine Disc Disease

R Chavez, W. Dillin and L. Amass
The P.A.I.N. Institute, Inc., Redondo Beach, CA and Kerlan-Jobe and Friends Research Institute, Inc. Los Angeles, CA, **2006**
Presented at the 67th Annual Conference of College on Problems of Drug Dependency, Scottsdale, Arizona, 2006

INSTITUTIONS
- The P.A.I.N. Institute, Inc., Redondo Beach, CA, USA.
- Kerlan-Jobe, Los Ángeles, CA, USA.
- Friends Research Institute, Inc., Los Angeles, CA, USA.

ABSTRACT BODY: Buprenorphine's analgesic properties are well known, but using the sublingual tablet (Subutex/Suboxone) pre-operatively to stabilize pain in opiate dependent chronic pain patients awaiting orthopedic surgery is unique and novel. Worsening pain in these patients may be due to opioid induced hyper-algesia and mistaken as a signal to proceed with surgery. Buprenorphine's anti-hyper-algesic effects may benefit these patients by reducing pain and enabling surgery to be postponed or cancelled. This report describes results with 18 opioid tolerant patients taking prescription opiates for severe pain due to lumbosacral (n=16) or cervical spine (n=2) disc disease. All patients were preoperative and referred before scheduling surgery by orthopedic and neuro surgeons to The P.A.I.N. Institute for buprenorphine treatment. Patients (11 male; 7 female) averaged 48 years old (range 33-69) and were mostly white (89%), insured (83%), working (95%) and college educated (95%).

Patients had been maintained on prescription opiates for a mean of 4.9 years (range 1-15), 12 had none and 6 had between 1 and 5 prior surgeries. After treatment with Subutex (n=13) or Suboxone (n=5), 89% (16/18) no longer required surgery. Surgery is being considered for 1 patient after 13 months on Subutex and another had surgery and has since returned to Subutex. To date, 89% (16/18) have continued buprenorphine maintenance at a mean daily dose of 19.1 mg (range 1-32) for a mean of 16.7 months (range 2-31). No patient has become tolerant to buprenorphine, nor has there been any medication misuse, diversion or safety issues. Pain ratings on a 10-pt scale averaged 6.9 before and decreased to 2.7 during treatment. These clinical findings support using Subutex/Suboxone for pain reduction in preoperative, opiate dependent chronic pain patients. The potential medical and economic benefits of buprenorphine treatment for avoiding surgical complications, time and work lost, and monetary costs to society are tremendous

IMPROVEMENT IN PAIN LEVELS AFTER TREATING OPIOID DEPENDENT CHRONIC PAIN PATIENTS WITH BUPRENORPHINE.

Rick Chavez, M.D.[1,2], Leslie Amass, Ph.D.[3], Jonathan B. Kamien, Ph.D. [3] and Lynette Prucha[2]

[1]UCLA School of Medicine, Los Angeles, CA, [2]The Pain Institute at Little Company of Mary, Redondo Beach, CA, and [3]Friends Research Institute, Inc., Los Angeles, CA

Presented at 3rd World Congress, World Institute of Pain, September 21-25, 2004
"Pain Advances in Research and Clinical Practice," Barcelona, Spain.

AIM OF INVESTIGATION: Managing opioid dependent patients with chronic pain is challenging and hampered by limited treatments. We explored buprenorphine sublingual tablets (BUP) for treating 65 opioid-dependent patients (34 male) with chronic severe pain at a multidisciplinary pain management center in Redondo Beach, CA.

METHODS: Patients received medical and psychological assessment at entry. Open-label treatment included maintenance or medically-supervised withdrawal using BUP over varying periods of time, urine drug screening, on-going pain assessment using a
0-10 rating scale, monitoring of adverse events and centralized case management. Concomitant medications were prescribed according to medical and psychiatric disorders. Patients averaged 47 years old (range 18-87), 6.4 years of opioid dependence (range 0.25-30) and prior treatment attempts for opioid dependence had been unsuccessful. To control pain, all patients used prescription Opioids (legally and illegally) and 5 also used heroin. Pain ratings at initial evaluation averaged 6.5 ± 0.2 (SEM). Common co morbid disorders included depression, anxiety, and musculo-skeletal maladies. All patients had stopped using Opioids before starting BUP 2 mg and BUP 8 mg tablets, two to four times per day, were prescribed according to patient need. Maintenance doses averaged 14.7 ± 1.1 (SEM) mg/day and maintenance are ongoing in 81% of patients.

RESULTS: Average pain ratings declined to 2.9 ± 0.3 (SEM) on maintenance BUP, and ongoing medical and non-substance abuse-related psychiatric problems were stabilized.

CONCLUSIONS: BUP therapy safely and effectively managed opioid-dependent Pain patients with co morbid chronic severe pain and reduced their pain ratings. Additional controlled research is needed to evaluate BUP for treating these opioid addicted patients.

Buprenorphine Tablet Treatment for Opioid Dependence in Patients With Co morbid Chronic Severe Pain

Rick Chavez, M.D. 1,2, Leslie Amass, Ph.D. 3, Jonathan B. Kamien, Ph.D. 3, and Lynette Prucha, MA 2

1UCLA School of Medicine, Los Angeles, CA, 2The Pain Institute at Little Company of Mary, Redondo Beach, CA, 3Friends Research Institute, Inc., Los Angeles, CA

Oral Presentation at The 66th Annual Meeting of The Conference on Problems in Drug Dependence (CPDD), San Juan, PR 6/04

AIM OF INVESTIGATION: Managing opioid dependent patients with chronic pain is challenging and hampered by limited treatments. We explored buprenorphine sublingual tablets (BUP) for treating 65 opioid-dependent patients (34 male) with chronic severe pain at a multidisciplinary pain management center in Redondo Beach, CA.
METHODS: Patients received medical and psychological assessment at entry. Open-label treatment included maintenance or medically-supervised withdrawal using BUP over varying periods of time, urine drug screening, on-going pain assessment using a 0-10 rating scale, monitoring of adverse events and centralized case management. Concomitant medications were prescribed according to medical and psychiatric disorders. Patients averaged 47 years old (range 18-87), 6.4 years of opioid dependence (range 0.25-30) and prior treatment attempts for opioid dependence had been unsuccessful. To control pain, all patients used prescription Opioids (legally and illegally) and 5 also used heroin. Pain ratings at initial evaluation averaged 6.5 ± 0.2 (SEM). Common co morbid disorders included depression, anxiety, and musculo-skeletal maladies. All patients had stopped using Opioids before starting BUP 2 mg and BUP 8 mg tablets, two to four times per day, were prescribed according to patient need. Maintenance doses averaged 14.7 ± 1.1 (SEM) mg/day and maintenance are ongoing in 81% of patients.
RESULTS: Average pain ratings declined to 2.9 ± 0.3 (SEM) on maintenance BUP, and ongoing medical and non-substance abuse-related psychiatric problems were stabilized.
CONCLUSIONS: BUP therapy safely and effectively managed opioid-dependent Pain patients with co morbid chronic severe pain and reduced their pain ratings. Additional controlled research is needed to evaluate BUP for treating these opioid addicted patients.

Buprenorphine Treatment for Opioid Dependence in Patients With Co morbid Chronic Severe Pain: An Open-Label Case Study Analysis

R Chavez and L Amass. UCLA School of Medicine, Los Angeles, CA and The Pain Institute at Little Company of Mary, Redondo Beach, CA; and Friends Research Institute, Inc., Los Angeles, CA

Poster presentation at "6th Annual Conference on Pain and Chemical Dependency in New York City, February 13-15, 2004"

Buprenorphine-only and buprenorphine-naloxone sublingual tablets became available for treating opioid dependence in the US in March 2003. Managing opioid dependent patients with multiple chronic pain issues is challenging and has been hampered by limited or non-existent effective treatments.

Objectives/aim: We explored using buprenorphine tablets for treating 13 opioid-dependent patients (8 male, 5 female) with chronic severe pain seeking treatment at a multidisciplinary pain management center in Redondo Beach, CA.
Methods: Patients received medical and psychological assessment at treatment entry. Open-label treatment included either maintenance or medically-supervised withdrawal using buprenorphine-only tablets over varying periods of time, urine drug screening, and ongoing pain assessment using a 0-10 rating scale, monitoring of adverse events and centralized case management. Concomitant medications were prescribed according to medical and psychiatric needs.
Results: Patients averaged 44 years old (range 34-68); 5 years of opioid dependence (range 2-10) and prior treatment attempts had been unsuccessful. To control pain, all patients used prescription Opioids (legally and illegally) and one patient also used heroin. Twelve patients requested addiction treatment; one patient became aware of her addiction after physician counseling. Pain ratings at initial evaluation averaged 7.4 (range 5-9). Common co morbid disorders included depression, anxiety, non-opioid substance dependence, and muscular-skeletal maladies. Two and 8 mg buprenorphine-only tablets, two to four times per day, were prescribed according to patient need. All patients were offered, but declined, once per day dosing. Maintenance averaging 12.7 mg/day (range 4-24) is ongoing in all but one patient who has since discontinued buprenorphine. All patients successfully withdrew from prescription Opioids within 5 days of starting buprenorphine, average pain ratings declined to 2.8 (range 0.5-7), and ongoing medical and non-substance use disorder psychiatric problems became stable. The most common side effects were extreme sleepiness, fatigue, migraine headaches, dizziness, disorientation and nausea, but reports were few, appeared dose dependent and eventually resolved.
Conclusions: Buprenorphine-only tablet therapy safely and effectively managed opioid-dependent patients with co morbid chronic severe pain and reduced their pain ratings. Additional controlled research to evaluate buprenorphine's role in treating this sub-population of opioid addicted patients and examine the role of other factors on their treatment outcome is needed.

RICK CHAVEZ, M.D.
Medical Director
THE P.A.I.N. INSTITUTE
Pain & Addiction Integrated Network, Inc.
Board Certified, American Board of Pain Medicine (ABPM)
Board Certified, American Board of Family Medicine (ABFP)
Board Certified, American Board of Addiction Medicine (ABAM formerly ASAM)
Former Assistant Clinical Professor of Family Medicine, UCLA Geffen School of Medicine

The P.A.I.N. Institute
510 North Prospect Avenue, Suite# 209
Redondo Beach, CA 90277
Phone: 310.798.1633
Cell: 323-228-8388; 323-833-8269
Fax: 310.374.1576
email: RickChavezMD@aol.com
email: PAINandADDICTION@live.com **web: www.PainAndAddiction.com**

THE P.A.I.N. INSTITUTE

Pain & Addiction Integrated Network, Inc

Rick Chavez, M.D.

Board Certified, American Board of Family Medicine
Board Certified, American Board of Pain Medicine
Board Certified, American Board of Addiction Medicine
510 North Prospect Avenue, Suite # 209
Redondo Beach, CA 90277
310 798-1633 (Office) 310 374-1576 (Fax)

06/26/2014

EXPLANATION OF CURRENT EXPERT WITNESS FEES.

To prospective counsel & associated staff, physicians, and the lay public,

It is important, as an expert witness that I continue to see patients who suffer from disorders that cause chronic pain and/or addiction disorders such as addiction to doctor prescribed opiate analgesic medications, stimulants, benzodiazepines, alcohol, cocaine, methamphetamine, and other drugs in my private medical office. By maintaining the highest standards of clinical and medical care in the practice of medicine, it gives my testimony and medical expertise the credibility and weight required of an expert reviewer and consultant to the legal community, the DEA, the Medical Board of California, the Attorney General of California, injured patients, medical practitioners, and the District Attorney of Los Angeles when my opinion and advice is requested. I believe that in order to provide an expert opinion, physicians must continue to practice in their specialty and fields of medicine when they are required to make a judgment in a clinical case. The "art and science of medicine" is very complex and difficult, and in order to fairly judge whether the standard of care provided by a medical provider in the community is acceptable or not, one must actually have practiced medicine in similar situations.

In addition, as a URAC certified Medical Director of the Utilization Review Firm "Health Care Resource Group" in Whittier, I am an expert in the utilization review of diagnostic and treatment interventions along with the modalities utilized in the evaluation of patients who require oversight of their physician's requests for requests to do invasive interventions such as epidural injections, morphine pump implantation, spinal cord stimulator implantation, spinal facet joint injections, breast reductions surgery, and many other therapeutic & diagnostic interventions. As a result, when I am asked to review a case for a plaintiff or a defendant, and I am asked to appear for deposition, or appear in court, I must cancel and rearrange my busy patient schedule to do so. Regardless, I must still pay for the substantial overhead of my medical office, along with malpractice insurance, and all staffing salaries & benefits to run a solo medical practice. As a result, I consider my hourly fees to be very reasonable for the expertise and opinions that I provide to the lay public, the government entities, and the legal and medical communities that I serve.

I would like to explain how these expert witness fees are created and reveal the rationale for how they were not arbitrarily arrived at but rather, are based on a review of over 1000 expert witnesses in all fields of medicine by SEAK, Inc. It is important to remember that in order to maintain my expertise and triple board certifications in Pain Medicine, Addiction Medicine, and FamilyMedicine, I must be a practicing physician who actively sees patients in all of these specialties.

Generally, I schedule on average, 15-18 patients per day in my office 3 to 4 days per week. My expert witness fees are based on the fact that I have to cancel my full patient schedule in order to be ready for testimony. Since, I have to re-schedule patients whenever I am asked to be an expert wittness, the income from those scheduled patients is lost for the day I am away. As a result, if testimony is cancelled, the more time that I have to re-schedule my patients after a scheduled deposition or court testimony is cancelled, the more likely I will be able to cover my practice overhead. This is the reason why there is a penalty when I am not given sufficient time to re-schedule my patients when I am told that I am not needed in court or for deposition. While, to some, the expert witness fees may seem high, in reality, they are quite fair given the time and energy it takes to prepare properly for testimony and for the expense of maintaining my medical practice and covering my overhead.

Air travel can be exhausting and stressful, and obviously requires more time out of the office, and as a result, expert witness fees are higher. Whether I am seeing patients, or not, I still have to pay my staff salaries, office rent, insurance, etc. and all of the other costs required to maintain my specialty practice.

Thank you for allowing me to explain this issue to you because it is important to me that you understand the factors involved when these fees are posted. In addition, I believe that it is important for your client, defendant or plaintiff, who you represent, to know how my fees were arrived at. The client needs to understand that the "right" medical expert, whose testimony may make a significant difference in the outcome of a case, can be invaluable.

When I take on a case, my goal is to provide you with a medical opinion based on clear and factual information that will help you get to a mutually agreeable settlement and, as a result, a satisfied client. It is always to my and your benefit, that I never have to leave my office, and with that goal in mind, that being said, I look forward to working with you in the future and I hope that you will find my participation in your case to be very beneficial to you and your client, whether they be defendant or plaintiff.

Rick Chavez, M.D.
Board Certified, American Board of Pain Medicine
Board Certified, American Board of Family Medicine
Board Certified, American Board of Addiction Medicine
Former Assistant Clinical Professor of Family Medicine, David Geffen UCLA School of Medicine (2002-7/2012)

Expert Witness Fees*

EXPERT WITNESS FEES & RATES (NON-GOVERNMENT) *

1. CANCELLATION FEES: (Cancellation Fee within 24 hours, 75% of minimum) Cancellation fee with 72 hours, 50% of minimum. Cancellation fee if reported within 1 WEEK (7 DAYS), 25% fee. and if cancelled prior to 1 week, no fee. charged. 1 WEEK CANCELLATION REQUIREMENT: NO EXCEPTIONS.

2. FILE AND RECORD REVIEW (NO REPORT): Hourly rate for file and record review: $500.00 / HOUR. (no written report) RETAINER / FEES: MINIMUM OF 4 HOURS FOR FILE REVIEW TO START $2000.00. Non-refundable.

3. FILE AND RECORD REVIEW WITH REPORT: Hourly rate for file review with formal written report: $575.00 / HOUR. RETAINER / FEES: MINIMUM OF 4 HOURS FOR FILE REVIEW TO START $2300.00. Non-refundable.

4. PRE-TRIAL PREPARATION FEES: Pre-trial preparation time: $400.00 / hour, minimum 4 hours

5. DEPOSITION IN MY OFFICE: Hourly rate for Deposition physically done at the Pain Institute in Redondo Beach: (minimum of 2 hours) $725.00 / HOUR. ½ DAY (4 HOURS) = $2900.00. ; FULL DAY (8 HOURS) = $5800.00. Must Cancel with 24 hours notice to avoid having to pay 75% of fees.

6. DEPOSITION WITHIN 2 HOURS OF MY OFFICE: Hourly rate for Deposition within 2 hours drive from the Pain Institute: $775.00 / HOUR PLUS TRAVEL TIME RATE. ½ DAY (4 HOURS) = $3100.00; FULL DAY (8 HOURS) = $6200.00. PLUS $250/ HR DRIVE TIME. Must Cancel with 24 hours notice to avoid having to pay 75% of fees.

7. TRAVEL TIME RATE: HOURLY rate for TRAVEL TIME: Portal to Portal $250.00 / HOUR OR $1000 FOR EVERY 4 HOURS, BUT If overnight stay then maximum of $2500 per day midnight to midnight (IF MORE THAN 10 HOURS).

8. DEPOSITION & COURT ROOM OUTSIDE OF STATE OF CALIFORNIA: Hourly rate for Deposition outside of CALIFORNIA: Rate for travel time or day rate plus $850.00 per hour, minimum 4 hours, paid in advance of deposition. ½ DAY RATE = $3400.00; FULL DAY (8 HOURS) $6800.00 Must Cancel with 24 hours notice to avoid having to pay 75% of fees.

9. COURTROOM HOURLY RATE IN LOS ANGELES COUNTY: Hourly rate for COURT ROOM TESTIMONY: In Los Angeles County $800.00 per hour with a minimum of 1/2 day (4 HRS). 1/2 DAY RATE = $3200.00; Full day rate (8 hrs) = $6400.00. plus travel time. (Cancellation Fee within 24 hours, 75% of minimum) Cancellation fee with 72 hours, 50% of minimum. Cancellation fee if reported within 1 week, 25% fee. and if cancelled prior to 1 week, no fee. charged.

10. COURTROOM HOURLY RATE OUTSIDE OF LOS ANGELES COUNTY BUT IN CALIFORNIA: Hourly rate for COURT ROOM TESTIMONY: Outside of Los Angeles County but in the state of California $825.00 per hour with a minimum of 1/2 day (4 hrs) = $3300.00; Full day rate (8 hours) = $6600.00. plus travel time. (Cancellation Fee within 24 hours, 75% of minimum) Cancellation fee with 72 hours, 50% of minimum. Cancellation fee if reported within 1 week, 25% fee. and if cancelled prior to 1 week, no fee. charged.

11. COURTROOM HOURLY RATE OUTSIDE OF CALIFORNIA: Hourly rate for COURT ROOM TESTIMONY: Outside of California $900.00 per hour with a minimum of 1/2 day (4 hours) every day in court = $3600.00 per 1/2 day. Full Day = $7200. Plus travel time. (Cancellation Fee within 24 hours, 75% of minimum) Cancellation fee with 72 hours, 50% of minimum. Cancellation fee if reported within 1 week, 25% fee. and if cancelled prior to 1 week, no fee. charged.

12. TRAVEL ARANGEMENTS: Travel Arrangements: Responsibility for coordination of travel to be done by retaining lawyer's staff. (Coordinate with Lynette Prucha, Administrative Director of The P.A.I.N. Institute.

13. CANCELLATION FEES: Within 24 hours of testimony, 75% of minimum fees. Within 72 hours, 50%, Within 1 week, 25%, and > than 1 week, full refund.

01. Require Signed Written Fee Agreement prior to beginning consultation : YES

02. Terms Contained in Expert Witness Fee Agreement: YES

03. Lawyer is responsible for fee, not lawyer's client: YES

04. Interest for delinquent accounts: YES, 2 % per month after grace period of 30 days upon completion of services.

05. Out-of-pocket expense policies: YES

06. Retainer/prepayment requirements: YES

07. In-court testimony minimum fees: YES

08. Retaining counsel will pay for all deposition charges: YES (FULL PAYMENT on the day of deposition for ALL estimated hours)

09. Fee schedules: YES

10. Attorney's fees if forced to sue for collection: YES

11. Portal-to-portal travel time: YES

12. Deposition minimum fees: YES

13. Payment for preparation time: YES

14. Air Travel: Business Class round trip plus cab fares

Fees were calculated and based on the SEAK, Inc. 2009 nationwide Expert Witness Survey.

Expert Witness Fees

SEAK, Inc.
Click here for SEAK's Expert Witness Directory
Excerpted from the text SEAK, Inc. National Guide to Expert Witness Fees and Billing Procedures

Click here to purchase the updated 2009 Expert Witness Fee Guide

Expert Witness Fees By Area of Expertise
The survey includes responses from over 1,000 expert witnesses in over 300 areas of expertise,

from Accident Reconstruction to Wound Care. This is the most comprehensive study ever conducted on expert witness fees.

There was significant variation in fees amongst different areas of expertise. Medical expert witnesses are on average better compensated than non-medical expert witnesses. The average hourly fee for in court testimony for all non-medical experts is $248. The average hourly fee for in court testimony for all medical experts is $555. Medical expert witnesses on average earn more than double (124% more) what non-medical expert witnesses earn. 45% of all responding experts were medical experts and 55% of all responding experts were non-medical experts.
Surprisingly, less experienced experts generally charge more than experienced experts. The median hourly rate for all experts for in court testimony was $300. The median hourly rate for experts who have been testifying 1-5 years was $350 and the median hourly rate for experts who have been testifying 26+ years was $275.

Expert Witness Fees for Trial, File Review and Depositions
On average, experts charge significantly more for their time while testifying at trial and deposition than their time while conducting file reviews and preparing. The average hourly fee for all experts was $385 for in-court testimony, $353 for depositions and $254 for file reviews and preparation. The average hourly fee for trial testimony is 52% higher than the average hourly fee for file reviews and preparation.

Minimum Expert Witness Fees for Depositions and Trial
A majority of all experts (58%) charge a minimum number of hours for depositions and trial testimony. Medical experts are far more likely to charge such a minimum. For example, 72% of medical experts have a minimum deposition charge. Only 46% of non-medical experts have a minimum deposition charge. The median minimum charge for all experts was 3 hours for depositions and 4 hours for trials.

Expert Witness Cancellation Fees for Depositions and Trials
45% of all experts have a cancellation policy whereby they retain all or portion of a deposition or trial appearance fee for cancellation made within a certain specified time prior to the scheduled date. Medical experts are far more likely to have such a cancellation policy. 69% of medical experts have such a policy, whereas only 25% of non-medical experts have such a policy. This may be reflective of a physician's inability to fill up his/her calendar with patients after cancellation is made on short notice.

Expert Witness Depositions
20% of all experts report opposing counsel having failed to pay them for at least part of the expert's deposition fee in the last five years. To avoid this situation, 48% of experts require advance payment from opposing counsel for depositions. Where the time of the deposition exceeds that prepayment amount, the vast majority of experts (77%) proceed with the deposition. However, a sizeable minority (23%) obtain payment before proceeding further. 38% of experts who require written retainer agreements include a clause in that agreement whereby retaining counsel agrees to pay for all deposition charges.

Expert Witness Retainers
The vast majority of all experts (73%) obtain some sort of up-front retainer. The median amount of this retainer is $1,500. Non-medical experts are significantly more likely to require a retainer than medical experts. 79% of non-medical experts require an up-front retainer, whereas only 65% of all medical experts require an up-front retainer. Requiring a replenishable retainer is a one way to

guarantee payment by retaining counsel. Of those experts requiring retainers, 69% use one time retainers and 31% use replenishable retainers.

A problem commonly faced by experts is being named as an expert in a case for the sole purpose of "conflicting the expert out" and denying the opposing sides the expert. One way to mitigate this problem is to require a nonrefundable retainer prior to reviewing any documents or doing any work on a case. 44% of all experts who require a retainer have their retainer be non-refundable.
Expert Witness Written Fee Agreements

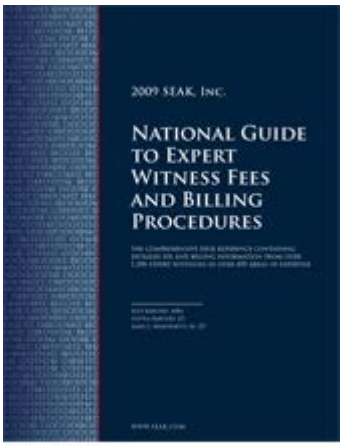
One of the most interesting facts is that less than half (46%) of all expert witnesses require retaining counsel to sign a written retention agreement. Non-medical experts are much more likely to require retaining counsel to sign a written fee agreement (58%) than medical experts (31%).

Expert Witness Collections Troubles
A significant number of expert witnesses reported retaining or opposing counsel failing to pay one of their bills in the preceding five years. Experts were far more likely to report collection difficulties with retaining counsel than with opposing counsel. 46% of all experts reported having retaining counsel fail to pay a bill in the last 5 years, whereas only 20% of experts reported that opposing counsel failed to pay a bill in the last 5 years.

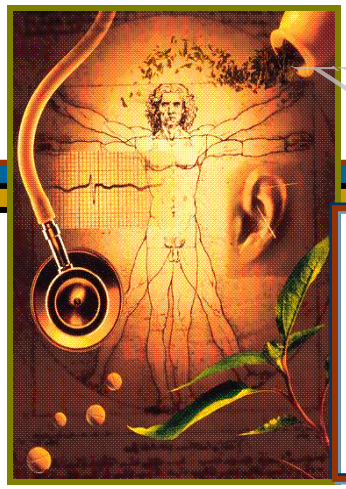
SEAK, INC. NATIONAL EXPERT WITNESS FEE SUMMARY DATA INCLUDES NON PHYSICIAN EXPERTS SUCH AS ENGINEERS, ARCHITECTS, ETC.
Responding Experts Witnesses: Surveyed 1030 experts
Years Testifying: High: 75 Low: 1 Average: 15.6 Median: 15
In Court Testimony (hourly): High: $7500 Low: $75 Average: $385 Median: $300
File Review/Prep (hourly): High: $1000 Low: $0 Average: $254 Median: $240
Depositions (hourly): High: $3000 Low: $0 Average: $353 Median: $300
Min. Charge for Depositions : 58%
Hours in Minimum: High: 12 Low: 1 Average: 3.1 Median: 3
Min. Charge for Trial: 58%
Hours in Minimum: High: 20 Low: 1 Average: 4.2 Median: 4
Cancellation Fee for Depositions or Trial: 45%
Deposition Payment in Advance: 48%
Up Front Retainer: 73%
Retainer Amount: High:$15,000 Low: $150 Average: $1967 Median: $1500
Type of Retainer: Refundable: 54% Partially Refundable: 2% Non-Refundable: 44% One Time: 69%
Replenishable: 31%
Depositions That Exceed Paid for Time:
Get Payment before proceeding: 23% Proceed without immediate payment: 77%
Out of Pocket Expenses Marked Up: 19%
Markup Amount: High:40% Low: 3% Average: 14% Median: 15%
Out-of Pockets Billed For:
Mileage: 68%
Airline Tickets: 83%
Photocopies: 44%
Telephone Calls: 38%
Lab/Testing: 41%
Photos: 45%
Demonstrative Aids: 48%
Travel Billed Portal-to-Portal: 86%
1st Class Airfare Required: 10%

Require Signed Written Fee Agreement: 46%
Terms Contained in Expert Witness Fee Agreement:
Lawyer is responsible for fee, not lawyer's client: 66%
Interest for delinquent accounts: 55%
Out-of-pocket expense policies: 78%
Retainer/prepayment requirements: 83%
In-court testimony minimum fees: 59%
Retaining counsel will pay for all deposition charges: 38%
Fee schedules: 82%
Attorney's fees if forced to sue for collection: 48%
Portal-to-portal travel time: 62%
Deposition minimum fees: 52%
Payment for preparation time: 65%
First class air travel: 10%
Majority of Work: Plaintiffs: 23% Neither: 57% Defendants: 20%
Type of Expert: Medical: 45% Non-Medical: 55%
Retaining Counsel Failed to Pay Last 5 Year: 46%
Opposing Counsel Failed to Pay last 5 Year: 20%
The book details:

- Summary of expert witness fees and billings by specialty area
  - State-by-state summary of expert witness fees and billing procedures
  - Individual expert witness fees and billing procedures
  - Hourly fees for file review depositions and trial testimony
  - Retainer types and amounts
  - Prepayment policies for trial and depositions
  - Out-of-pockets billed for and whether and how out-of-pockets are marked up
  - Terms contained in written fee agreements
  - Cancellation fees
  - Minimum charges for depositions and trial
  - Billing procedures for travel time
  - History of collection difficulties with retaining and opposing counsel
  - Detailed statistical information, analysis and more



Updated 2009 Expert Witness Fee Guide



THE P.A.I.N. INSTITUTE

Pain & Addiction Integrated Network, Inc

510 NORTH PROSPECT AVENUE, #209
REDONDO BEACH, CA 90277
310 798-1633 310 374-1576 (FAX)
www.PainAndAddiction.com

October 20, 2012

MEDICAL BOARD OF CALIFORNIA ENFORCEMENT PROGRAM

SENIOR INVESTIGATOR:	N Z, SENIOR MEDICAL BOARD INVESTIGATOR
SUPERVISING INVESTIGATOR:	S R, SUPERVISING INVESTIGATOR
DEPUTY ATTORNEY GENERAL;	M C, ESQ., DEPUTY ATTORNEY GENERAL
ADDRESS:	SAN BERNADINO DISTRICT OFFICE W. 4TH STREET, SUITE 429 SAN BERNADINO, CA 92401 TEL: 909-383 XXXX FAX:909-383-XXXX

SUBJECT: Z B, M.D.
CASE#: 09-2011-XXXXX
PATIENTS: D Z; A M; A S

I. PHYSICIAN REVIEW

PHYSICIAN REVIEWED:	ZB, M.D.
LICENSE TYPE:	ALLOPATHIC PHYSICIAN & SURGEON
LICENSE NUMBER:	CALIFORNIA
DOB:	05/11/1968
DEA:	BXXXX537
CA LICENSE:	A XXXXX
LICENSE STATUS:	EXPIRES: 05/31/2013; ISSUED: 9/01/1995
MEDICAL SCHOOL:	GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE
YEAR GRADUATED:	1994
BOARD CERTIFIED:	YES, TWICE BUT NOW EXPIRED. SHE PLANS TO RE-APPLY FOR EXAM IN THE FUTURE.
HOSPITAL PRIVELAGES:	YES IN THE PAST BUT NONE CURRENTLY.
RESIDENCY TRAINED:	FAMILY MEDICINE, UCLA NORTHRIDGE, CALIFORNIA
OFFICE ADDRESS:	M P. M.D., Inc. XXXXCorona Mall Corona, CA 92879
RESIDENCE:	Anaheim, CA 92807

II. MATERIALS REVIEWED

1. BINDER #1:
   A. Letter from Medical Board of California dated 09/25/2012 from NATALIE ZZZZZZ, Senior Investigator
      1. INVESTIGATION REPORT
      2. ATTACHMENT #1: Consumer Complaint from DENISE XXXX.
      3. ATTACHMENT #2: Empty, not for review
      4. ATTACHMENT #3: C.U.R.E.S. for Ms. XXXX, XXXX DDDD, M.D. 9/2/09-7/28/10.
      5. ATTACHMENT #4: C.U.R.E.S. for Ms. AMY XXXX , XXXX DDDD, M.D. 04/29/09-5/22/11
      6. ATTACHMENT #5: Authorization for release of medical informat. signed by DENISE XXXX.
      7. ATTACHMENT #6: Medical Records Request for DENISE XXXX dated 8/19/11, CORONA FAMILY CARE
      8. ATTACHMENT #7: Authorization for Release of Medical Informat. for Ms. AMY XXXX , 11/16/11
      9. ATTACHMENT #8: Authorization for Release of Medical Informat. for Ms. ANNETTE M. XXXX 12/2/11
      10. ATTACHMENT #9: Medical Records of AMY XXXX
      11. ATTACHMENT #10: Medical Records of ANNETTE XXXX .
      12. ATTACHMENT #11: Medical Records of AMY XXXX , multiple providers DR. XXXX , DR.

XXXX , P.A. ZZ.

13. ATTACHMENT #12: Medical Records of ANNETTE XXXX

2. BINDER #2

1. ATTACHMENT #13: Employment History of XXXX DDDD
2. ATTACHMENT #14: Transcript of Interview, April 25, 2012
3. ATTACHMENT #15: Prescription records
4. ATTACHMENT #16: Prescription records
5. ATTACHMENT #17: Prescription records
6. ATTACHMENT #18: Prescription records
7. ATTACHMENT #19: Prescription records
8. ATTACHMENT #20: Prescription records
9. ATTACHMENT #21: Prescription records
10. ATTACHMENT #22: Pharmacy records
11. ATTACHMENT #23: Pharmacy records
12. ATTACHMENT #24: Pharmacy records
13. ATTACHMENT #25: Pharmacy records
14. ATTACHMENT #26: Pharmacy records

III. POTENTIAL CHARGES (California Legal Codes):

1. Business & Professions Code 725-Excess treatment or Over-prescribing.
2. Business & Professions Code 2234 Unprofessional Conduct
3. Business & Professions Code 2241 (d)-Prescribing to an Addict.

IV. INVESTIGATION REPORT

1. ALLEGATIONS:

A. DENISE XXXX, 2/15/2011:

a. "Dr. XXXX DDDD was over prescribing to DR. XXXX 'S friends, neighbors, and family, and provides samples in her house." DR. XXXX "has multiple samples in her house and provides a variety to try them out for depression, anxiety, pain, and weight loss."

b. "DR. XXXX wrote prescriptions for BENZPHETAMINE, DIDREX, and PHENTERMINE. Samples alleged to be offered were LEXAPRO, PROZAC, and CYMBALTA." At her visit on 9/30/09 Ms. XXXX WAS TREATED WITH PHENTERMINE 37.5 MG FOR OBESITY. On 12/09/09 the VISIT WITH XXXX DDDD, M.D. had the diagnosis of being "Overweight" and she was prescribed DIDREX because at her previous visit she had been prescribed Phentermine 37.5 mg bid,

c. On 4/5/2011 C.U.R.E.S. 2010-11 report reviewed, and on 6/6/11 C.U.R.E.S. for DR. XXXX was reviewed.

d. DR. XXXX is a neighbor of MS. XXXX. Their children are friends. Ms. XXXX had been to see DR. XXXX a few times for "weight loss" therapy. She was prescribed PHENTERMINE & LEXAPRO. MS.XXXX informed DR. XXXX that her KAISER physician prescribed MS. XXXX WELLBUTRIN, and Told DR. XXXX that the WELLBUTRIN was not working. She alleges that DR. XXXX gave her (MS. XXXX) samples of LEXAPRO & CYMBALTA that she had at her (DR. XXXX 's) residence. Ms. XXXX claimed that "DR. XXXX has cabinets filled with samples and has needles in her garage." "She claimed that another neighbor who has breast cancer "was offered medications" but she (the neighbor) declined" the medications. This is an unsubstantiated accusation.

e. DR. JASON ZZZZ, the district medical consultant chose 2 patients to review based on what he found on the C.U.R.E.S. reports.

B. C.U.R.E.S. ANNETTE XXXX

a. HYDROCODONE/APAP 7.5/325: #90 2/19/10, (11 DAYS) #60 3/2/10, #60, (6 DAYS) 3/8/10, #90 (2 DAYS) 3/10/10, #90 (0 DAYS) 3/10/10, #90 (7 DAYS) 3/17/10, #90 (2 DAYS) 3/19/10, #90 (10 DAYS) 3/29/10, #90 (10 DAYS) 4/8/10, #90 (16 DAYS) 4/26/10, #90 (25 DAYS) 5/21/10, #90 (21 DAYS) 6/11/10, #90 (19 DAYS) 6/30/10, #90 (8 DAYS) 7/8/10 REFILL, #30 (25 DAYS) 8/3/10, #6 (15 DAYS) 8/18/10, #90 (12 DAYS) 9/1/10, #90 (0 DAYS) 9/1/10, #90 (6 DAYS) 9/7/10, #120 (13 DAYS) 9/20/10, #120 (10 DAYS) 9/30/12, (3 DAYS) PERCOCET 10/325 #60 10/3/11, #120 (1 DAY) 10/4/10, #120 (14 DAYS) 10/18/10, #120 10/325 (7 DAYS) 10/25/10, #180 (2 DAYS) 10/27/10, #120 (13 DAYS) 11/8/10, #120 (8 DAYS) 11/16/10, #10 (20 DAYS) 12/6/10, #30 (3 DAYS) 12/9/10, #60 (0 DAYS) 12/9/10, #150 (2 DAYS) 12/11/10, #120 (9 DAYS)12/20/10, #4 (13 DAYS) 1/2/11, (17 DAYS) #26 1/19/11,(30 DAYS) #60 2/19/11, (90 DAYS)#20 5/19/11,

C. C.U.R.E.S. DENISE XXXX

a. PHENTERMINE30 MG #60 9/2/09, 37.5 MG #60 11/2/09, 30 MG #30 7/28/10

b. BENZPHENTAMINE HCL 50 MG #60 10/2/09, 12/3/09, 12/30/09, 1/28/10, 3/22/10, 4/30/10,

D. C.U.R.E.S. AMY XXXX

a. NORCO 325/7.5 MG #60 1/19/11, (14 DAYS) #40 2/3/11, #20 (9 DAYS) 2/12/11, #30 (10 DAYS) 2/22/11, #30 (4

DAYS) 2/26/11, #30 (6 DAYS) 3/4/11, #20 (7DAYS) 3/11/11, #10 (1DAY) 3/10/11, #30 (7 DAYS) 3/17/11, #30 (4 DAYS) 3/21/11, #15 (5 DAYS) 3/26/11, #20 (2 DAYS) 3/28/11, #20 (3 DAYS) 3/31/11, #5 (2 DAYS) 4/2/11, #60 (2 DAYS) 4/4/11, #60 (9 DAYS) 4/13/11, #30 (34 DAYS) 5/17/11, (4 DAYS) #30 5/22/11,

V. MEDICAL RECORDS

A. AMY XXXX , DOB: 3/11/80

a. VISITs on 11/16/05, 12/20/06 were with PA- TOM ZZ, and at the visit dated 1/12/67 the PA treated the patient with XANAX, and on 1/18/07 PA TOM ZZ noted patient insisted on getting NORCO, but received Ultram instead. The VISIT on 1/31/07 the patient c/o CHEST PAIN AND MUSCLE PAIN with PA TOM ZZ and was treated with ALPRAZOLAM & DEPAKOTE. The next VISIT was on 2/23/07 again with PA TOM ZZ. At the next VISIT on 3/8/07 with JEFF XXXX , M.D. the patient was given NORCO #20 for back pain after an apparent Fall. The VISITs on 3/21/07, 4/5/07, 5/16/07, 5/24/07, 5/31/07, were all with PA TOM ZZ. The patient complained of BILATERAL EAR PAIN and that the DEPAKOTE was NOT WORKING to PA TOM ZZ on 6/15/07, and on 6/22/07 she complained that a TAMPON was STUCK and she was WORRIED ABOUT INFECTION. Other visits were on 7/16/07 and 8/1/07 and she expressed a DESIRE for ANOTHER prescription for ANXIETY MEDICATIONS, 9/14/07, 10/29/07 BREAST BIOPSY BENIGN 1ST MENTION OF AMBIEN, XANAX, & VICODIN, 11/28/07 STOMACH PAIN AND CANT TOLERATE BUSPAR, 1/14/08 BACK PAIN VAGINOSIS AND MISCARRAIGE, 3/7/08 PHYSICAL AND PAP, INCREASED CELEXA, 4/11/08 MENTIONED VICODIN ES, 7/9/08 STOMACH PAIN DECREASED CELEXA & ADDED EFFEXOR, VISIT FELL AND HIT HEAD, DEPRESSED AND CRYING 9/3/08 ADDED PROZAC PA TOM ZZ, At the VISIT dated 10/17/08 she stated that her "PURSE was STOLEN AND VICODIN was TAKEN" prescribed by DR. XXXX #30 VICODIN ES, the VISIT on 11/20/08 was for COUGH, CHEST CONGESTION and FOOT PAIN and PA TOM ZZ expressed CONCERN OVER the presence of BIPOLAR VS SCHIZOPHRENIA, AND INCREASED PROZAC; and at the next visit she c/o an EAR ACHE, BACK PAIN, ANXIETY & DEPRESSION, AND STOMACH PAIN ON 12/16/10 AND DR. XXXX WROTE FOR NORCO 7.5 MG FOR BACK PAIN AND PROZAC FOR ANXIETY & DEPRESSION.

At the VISIT dated 1/19/11 she asked for a refill of XANAX AND DR. XXXX PRESCRIBED XANAX & NORCO. At the VISIT dated 2/3/11, also WITH DR. XXXX she was begging for pain medications also. The VISIT WITH DR. XXXX ON 4/22/11 FOR c/o "1 WEEK OF NECK PAIN AND TREATED WITH NORCO 7.5 MG, AND XANAX." There was a VISIT ON 7/26/11 WITH DR. XXXX , and a VISIT ON 8/8/11 WITH DR. XXXX for an injured right ankle. The next visits with DR. XXXX were on 8/22/11, 9/8/11 and she accused someone of taking her medications. At the visits on 9/26/11, 10/24/11, and 11/7/11 she says that MEDICATIONS were TAKEN FROM HER BOTTLES AT HER BROTHER'S HOUSE, and at the 11/29/11 visit It was decided that she would WEAN OFF PROZAC AND START CYMBALTA go on VICODIN HP and refilled ALPRAZOLAM 2 MG TIC.

b. Only 3 visits (12/16/10, 1/19/11, 2/3/11), were with DR. XXXX out of 38 visits.

c. DRUGS PRESCRIBED OVER 4 YRS INCLUDE: DEPAKOTE 250 MG, XANAX (ALPRAZOLAM) .25 MG, THEN .5 MG,THEN 2 MG TID, NORCO 10/325 TID to QID, FLEXERIL 10 MG TID, NAPROSYN 500 MG, VICODIN HP PROZAC(FLUOXETINE) 10 MG Q D, EFFEXOR XR, CYMBALTA, VICODIN ES, DIAZEPAM 5 MG TID, REMERON 30 MG SOLTAB HS 6RF, AMBIEN 10 MG HS, CELEXA 40 MG, IBUPROFEN, BUSPAR 15 MG, PRILOSEC 40 MG, RANITIDINE 300 MG, ULTRAM, FELDENE 20 MG, ENTEX PSE, CITALOPRAM, PROVENTIL INHALER, OMEPRAZOLE 40 MG, ZITHROMAX,

d. MEDICAL DIAGNOSIS INCLUDED: Anxiety, Depression, PTSD, Insomnia, Rule out Schizophrenia, Rule out Bipolar, Neck pain, Back pain, Otitis, Vaginosis, GERD, Headaches, Chronic pain, Elevated Liver Function Tests, Hyperlipidemia.

e. LAB WORK POSITIVE WITH SGOT of 135 and SGPT of189 on 1/28/11, CHOL 250, NL TSH, TFTs,

B. ANNETTE XXXX , DOB: 12/29/67

a. The VISIT vital signs for 11/3/08 WITH DR. XXXX were BP 174/74, WT 206 LBS, RAN OUT OF MEDS, STOPPED 1 WK PRIOR, DEPRESSED but Not SUICIDAL, CRYING, and NOTED TO BE suffering with OCD and treated with EFFEXOR. She was Diagnosed with D EPRESSION and OCD, and given a F/U IN 1 MO AND Given samples of PRISTIQ told to check HER BP IN 1 WK.

b. At the VISIT on 4/9/09 it was noted that she had LOST 8 LBS, BP 122/74, CHECKED GENERAL APPEARANCE and ABD. NO MEDS NOTED. DX: IBS? The Patient's diarrhea is most likely due to "BYPASS SURGERY." treated with DONNATOL 1-2 TID TO QID. She was given a sample of Wellchol. No insurance so no blood work. Wait for GI referral once she has insurance.

c. At the VISIT dated 8/5/09 her weight was 180 LOST TOTAL OF 26 LBS. Took Mom's VICODIN AND felt better. wants to try 1-3 per day. She denied addiction problem. DX: IBS TXD with VICODIN TID #90 Stated inappropriate, but states not addictive.

d. VISIT 12/21/09 Lost additional 7.2 lbs to 172.8 lbs. Internal hemorrhoids and diarrhea. Checked appearance lungs, heart, rectal stool guiac negative. Digital negative. Surgical consult, "concerned with chronic

narcotic use." Wrote again no addictive propensity, refilled NORCO. Prescribed ANUSOL.

e. VISIT 2/23/10. Wt now 204 lb, gained 31 lb. Just discharged from hospital with edema and sepsis. Now had an abscess. Vagina was swollen. 2+ pitting edema. Refused CBC because no insurance. Still with diarrhea. Anemia.
f. VISIT 3/2/10, 1 WEEK LATER, WT. 176.2, LOST 28 LB. DUE TO EDEMA AND DIURESIS WITH LASIX. Took her moms Vicodin again. She DCd NORCO DUE TO N/V. SKIN MUCH IMPROVED. Given Vicodin #60.
g. VISIT 3/9/10, 1 WEEK LATER. WT. 166, LOST ADDITIONAL 10 LBS, TOTAL LOSS 40 LBS IN 1 YR. CONT ON LASIX AND VICODIN.
h. VISIT 3/29/10, 4 WEEKS LATER WT 164 LB, LOST ADDITIONAL 2 LBS. DX: DEPRESSION
i. VISIT 7/7/10. WT 160.8 LBS. LOST ADDITIONAL 3 LBS. HX OF HEMMORRHOID BLEED. HGB 10.8. NO EXAM. REFER TO DR. GORSKY. FBS 122.
j. COPY OF SCRIPT FOR NORCO #6 8/18/10.
k. VISIT 9/2/10. WT 143 LB, LOST ADDITIONAL 16 LBS. REQUESTED HOSPITAL RECORDS. CHRONIC DIARRHEA. ON NORCO, HUSBAND CONTROLS.
l. 9/13/10, NOTE: Patient was informed that she needed to see a gastroenterologist. She was given info for a referral to Moreno Valley County Hospital. The patient refused to follow through due to the expense. DR. XXXX called in NORCO #120, and she called the office numerous times for refills.
m At the VISIT dated on 10/4/10 her WEIGHT WAS 137.8 LBS, AND SHE LOST AN ADDITIONAL 5 LBS. She was diagnosed with a VIRAL URI AND CHRONIC DIARRHEA.
n. REFILL REQUEST 11/8/10 FOR NORCO #120.
o. VISIT 11/8/10 STILL HAD NOT SEEN GI. She was REFERRED TO a COUNTY facility. She was ASKED TO WEAN off of NORCO
p. VISIT 11/16/10 WT. 152 LBS. DX: ANXIETY, DEPRESSION, MALABSORPTION, ADDICTION. She was REFERRED TO GI and treated with NORCO 4 PER DAY.
q. 1/3/11 Admitted to hospital again. DR. XXXX denied meds and insisted that she see a pain specialist and GI. She had rectal prolapse. Called in pain and she was told to go to ER.
r. On 1/5/11 the Patient c/o a UTI, SHE CALLED THE OFFICE IN WITHDRAWAL. SHE HUNG UP ON DR. XXXX .
s. VISIT 3/16/11, DX OF MALNUTRITION. NORCO 10/325#90 by Dr. XXXX The PIC LINE was IN PLACE. CHRONIC PAIN, HYPERTENSION. 03/17/2011 PERCOCET 5/325#30 through Riverside County General Hospital Dr. LUDI. She was STILL ON NORCO 10/325 MG. WT INCREASED TO 164.7 LBS. 03/23/2011 NORCO #15 Dr. SSSS. 03/27/2011 #30 NORCO 10/325 Dr. SSSS. NORCO 10/325#30 04/02/2011 Dr. SSSS. NORCO 10/325#120 04/03/2011 Dr. LEE. NORCO 10/325#45 04/09/2011 Dr. ZZZZ NORCO 10/325#30 04/09/2011 Dr. SSSS, NORCO 325/10#45 04/11/2011 Dr. ZZZZ. NORCO 10/325#90 04/13/2011, Dr. ZZZZ. NORCO 10/325#120 04/20/2011 Dr. ZZZZ; 04/30/2011 NORCO 5/325#30 Dr. ARAKAKI. NORCO 5/325#30 on 05/01/2011 Dr. ARAKAKI. NORCO 10/325#180 05/03/2011 Dr. ZZZZ. NORCO 10/325#9090 11/20/2011 Dr. ZZZZY. NORCO 10/325#25 05/16/2011 Dr. ZZZZy. NORCO 10/325#33 05/17/2011 Dr. ZZZZy, #25 NORCO 10/325 05/17/2011 Dr. ZZZZy. NORCO 10/325 #7 05/18/2011 Dr. ZZZZy, May 19 2011 PERCOCET 10/325#20 Dr. ZZZZy.
t. Typewritten progress notes on 5/11/11 NO SUBJECTIVE WRITTEN but ASSESSMENT with depression, IBS, and Chronic Diarrhea though due to previous bypass surgery. Seen on 6/2/11 NO SUBJECTIVE BUT ASSESSMENT for chronic diarrhea and treated with NORCO, and recommended GI. NORCO 325/10 #120 06/03/2011. 06/09/2011 PERCOCET 10/325#20. Seen again on 6/20/11 "Begging and crying for medications. Her story is that the hospital lost her prescription. All by Dr. XXXX . Prescribed NORCO #10 on 06/20/2011. ENDOCET 10/325#5 06/20/2011, Paxil is not working, and she sees GI, ASSESSMENT is for Depression, Narcotic Addiction, and again asked the patient to "find another doctor." Referred to Psych. 07/11/2011 PERCOCET #1510/325, LORAZEPAM 0.5 mg #30 on 07/11/2011, Seen on 7/13/11 Note not finished. NO SUBJECTIVE FILLED IN. Blank Assessment and discussion. PERCOCET 10/325#120 07/13/2011 Visit on 7/18/12 not completed. NORCO 10/325 #25 07/18/2011. BLANK SUBJECTIVE. No diagnosis, assessment, or discussion.
u. VISIT 7/16/11 WT 143.4 LBS FOR F/U. GIVEN PRISTIQ SAMPLE, SURGERY PENDING, LAMICTAL 25 MG 1-4 Q HS #120.
    1. in addition, Ms. SSSSS received #15 NORCO 7.5/325 on 05/20/2011. Dr. SSSSS
    2. Dr. Alli DDDD prescribed NORCO 10/325#15 on 06/01/2011 and #120 on 06/03/2011. #25 on 06/17/2011 and LORAZEPAM 0.5 mg #25 on 06/17/2011.
    3. Prescriber Dr. ZZZZ prescribed #180 NORCO 10/325 on June 21,
    4. Prescriber Dr. ZZZZY HAGAN NORCO 10/325#90 on 07/01/2011
    5. Dr. TRAN NORCO 10/325#20 on 07/01/2011
    6. Dr. RRRR described NORCO 10/325#12 on 07/12/2011
    7. Drs. T prescribed NORCO 7.5/750#16 on 07/19/2011. LORTAB 5/500#9 on 07/22/2011,
    8. digit is Dr. LAT described NORCO 5/500#21 on 07/24/2011.
v. Visit on 7/20/11 BLANK SUBJECTIVE, ASSESSMENT, AND PLAN. All by Dr. XXXX . 7/28/11 SAYS PT HERE FOR REFILL OF PAIN MEDICATIONS. NORCO 10/325#50 on 07/28/2011. Visit 8/30/11 noted amenorrhea. Visit 9/21/11 with BLANK SUBJECTIVE. Told to go to the county hospital. Seen 10/10 and crying hysterically. Started on NEURONTIN. Seen on 12/5/11 and the doctor is asking her patient to see a pain management and GI specialist.

w. Prescription filled by ZZZZY P. HAGAN, M.D. on 5/16/11 for NORCO 10 MG/325 MG #90. LORAZEPAM 0.5 MG #30 8/9/11.

x. Prescription refills:

1. Prescriber: J. SSSS: #15 NORCO 3/23/11
2. Prescriber: H. SSSS: NORCO 3/27/11 #30, 4/2/1 #30, 4/9/11 #30,
3. Prescriber: Z. XXXX : HYDROCOD 5/500 3/2/10 #60; 3/8/10 #60; 7.5/325 MG 3/10 #90; 6/19/10 #90; 12/9/10 #30; LORTAB 10/666 #60 2/15/11; NORCO 10/325 MG #120 6/3/11; PERCOCET 10/325 MG #10 7/28/11; NORCO 10/325 #50 7/29/11 NORCO +1RF; NORCO 7/30/11 #50 +2RF; #30 PERCOCET 8/15/11; #10 NORCO 10/325 MG 8/16/11; #120 NORCO 10/325 MG 8/17/; PERCOCET 10/325 MG #60 8/26/11; NORCO 5/325 MG #75 8/30/11; NORCO 10/325 MG #75 8/31/11; NORCO 10/325 MG #75 9/1/11
4. Prescriber: M. DDDD: HYDROCOD/ACET 5/325 MG #8/13/10 #30
5. Prescriber: M. DDDD: NORCO 10/325 MG, #5 8/25/12; #10 8/28/10; #15 5/11/10; #10 12/4/10 #10 12/5/10;
6. Prescriber: J. XXXX : NORCO 7.5/10 #15 11/5/10;
7. Prescriber: H. OOOO: NORCO 5/325 MG #30 1/28/11;
8. Prescriber: M. BBBB: NORCO 10/325 MG #40 1/12/11
9. Prescriber: T. TTTT DDS: 8/7/11 LORTAB 5/500 MG #21
10. Prescriber: PAUL TTTT, M.D. NORCO 10/325 MG #20 8/20/11;
11. Prescriber: SY RRRR, M.D. PERCOCET 5/325 MG #20 8/22/11

w. LABORATORY EVALUATION:

1. ANEMIA H/H 35.5/11.9, LEUKOPENIA WBC 3.3, CALCIUM 7.7 due to T. PROT 5.6, FERRITIN 5. 6/22/07
2. ABD. X-RAY: UNCHANGED. 12/25/10.
3. DUPLEX LE, 12/16/10: NO DVT.
4. ABD. US, 12/16/10: HEPATOMEGALY, PRIOR CHOLECYSTECTOMY, PROMINENT CBD diameter to 7 MM NO MASS OR STONE.
5. CT HEAD W/O CONTRAST: NEGATIVE 12/25/10.
6. CXR 12/25/10: BIBASILAR ATELECTASIS. NO CHF.
7. ABDOMINAL US. 12/29/10 LOCULATED FLUID.
8. CT CHEST WALL W/O CONTRAST. BILATERAL EFFUSIONS AND SMALL ATELECTASIS.
9. CT OF ABD/PELVIS: ASCITES.
10. PROLONGED PT, ANEMIA.

C. BRUCE XXXX

a. Mr. XXXX is possibly a neighbor of Dr. XXXX . Mr. XXXX may be DENISE XXXX's husband.
b. METHYLPHENIDATE 20 mg #60 prescribed by Dr. XXXX on 10/29/2011, #10 on 11/09/2011, #60 on 11/15 2011,
c SUBOXONE 18 mg #30 on 11/2/2011, #60 on 12/29/2011, #34 on 01/12/2012.
d. ALPRAZOLAM 0.5 mg #60 on 11/09/2011,
e. NORCO 10/325 mg #87 12/04/2011, #153 12/06/2011,
f. ZOLPIDEM 10 mg #90 12/04/2011
g. RITALIN 20 mg #60 12/08/2011
h. HYDROMORPHONE 4 mg #60 09/20/2011

VI. MEDICAL BOARD INTERVIEW:

1. INDVIDUALS PRESENT AT INTERVIEW:
   A. CALIFORNIA MEDICAL BOARD INVESTIGATOR NATALIE ZELMER
   B. JASON ZZZZ, M.D., DISTRICT MEDICAL CONSULTANT
   C. JENNIE PPPP, ASSOCIATE COUNSEL WITH MR. PPPP.
   D. MARK PPPP, ESQ., ATTORNEY FOR DR. XXXX WITH CARROLL, KELLY, TROTTER, PPPP & ASSOCIATES.
   E. MICHAEL CCCC, ESQ., DEPUTY ATTORNEY GENERAL, STATE OF CALIFORNIA
   F. XXXX DDDD, M.D., PHYSICIAN BEING INVESTIGATED

2. INTERVIEW FINDINGS:
   A. DENISE XXXX:
      1. 1ST Seen on 9/30/09 requesting diet pills. She had been on diet pills intermittently in the past and wanted to continue. She wanted to lose 20-30 lbs. She wanted to restart what she had been on in the past.
      2. Dr. XXXX stated that she listened to her heart but didn't write it down. She prescribed PHENTERMINE.
      3. Ms. XXXX was next seen on 12/2/09 requesting DIDREX because it worked better than PHENTERMINE.
      4. DR. XXXX states that she performed a blood pressure check and noted a 3 lb weight loss.
      5. Visits on 09/30 and 12/2, or about 2 months apart. On 9/30 she prescribed 30 tabs of PHENTERMINE 37.5 MG Twice daily.
      6. DR. XXXX states that she would have listened to her heart and lungs but didn't write it down. BP 142/92,

Heart rate 64. Weight 164 lbs, height 5' 7.'' But corrected by MR. PPPP as 5' 9" but no acknowledgement. DR. XXXX did not know the patient's BMI. Not morbidly obese. Did not discuss diet or exercise into the program. But DR. XXXX recalled that the patient was into Jazzersize. The goal is 5 lbs per month. The goal was to go from 164 lbs to 140 lbs.

7. Mr. CCCC pointed out that this is "stage I hypertension" but DR. XXXX called it borderline.
8. Mr. PPPP stated 134/80, perhaps referring to December visit. Heart rate 66. "I am sure that I listened to her heart. But no documentation at either visit. Despite lack of written documentation, she assures interviewers that she consistently examines patients, but she can't say why she didn't document it.
9. Patient previously had been on DIDREX previously sometime before visits with DR. BENJAIN.

B. AMY XXXX ;

1. First seen on 12/16/10 for a complaint of ear pain. A sticky note written by DR. XXXX saying that the patient needed a visit for a complet physical exam, well woman care, pap smear, and mammogram.
2. Ear pain, history of stomach problems, bilateral ear pain, back pain. Also, noted Depression/anxiety, Questionable otitis externa. She stated that she was assuming that she saw a little bit of drainage. She Said followup pap, physical. She was placed on FLUOXETINE 20 MG. Psychiatry referral. Then she gave her NORCO "which I assume for the back pain." She wasn't sure if the portion cut off was her hand writing.
3. She had been on meds, including DEPAKOTE, since 11/20/08. She stated that she was on VICODIN for back Pain, XANAX, PROZAC, & DEPAKOTE.
4. Next encounter date is 1/19/11came in for a physical exam, pap, and requested mammogram. Requested Refill of XANAX, and NORCO. She was on her period, but did a pap anyway. Well woman care, Bipolar, Pap was difficult. She prescribed REMERON 30 mg at bedtime, and a referral to MAMMOGRAM. Referred for Blood work and refilled XANAX 1 a day, NORCO bid, No refills.
5. Dr. ZZZZ asked about the "process" for keeping track of pain medication, and what evaluation needs to be Done.
6. DR. XXXX 's response to the question of whether she did a x-ray or work-up? "I'm sure I did." She said that she tried to "make them come in monthly. The problem with severe pain is that it's difficult to assess."
7. Next visit, 2/3/11 "Begging for pain meds." Reading record, may have recommended abdominal Ultrasound But couldn't tell. Negative abdomen ROS and exam. Increased LFTs due to DEPAKOTE? She noted Abdominal pain and wrote "strong psych component." Hepatic panel, hepatitis C, sed rate."We may need to Decrease DEPAKOTE, and DR. XXXX gave her a refill. DR. XXXX tried to explain the difficulty that She had with her patient begging her for pain medications because of severe pain. "I do feel a lot of Compassion. I try my best . . . I try to make the right decisions." "It's just a different situation when you are sitting across the table." Prescribed #60 tablets, no refills.
8. In reviewing the chart, it became clear to the group that the patient was under the care of DR. XXXX after February 3, 2011 and although some refills on the C.U.R.E.S. report may have really been from others in the Group, although DR. XXXX may have okayed a few when she rapidly okayed refills brought in by her Office nurse or staff. The board may not have gotten all of the records.
9. Dr. XXXX said that she had referred the patient to pain management and the referral was denied by the Group. Perhaps because of managed care, although this explanation is not that clear. Also, a pain contract Was requested by DR. XXXX but "denied." Who denied it is not clear. They did find a referral to A Psychiatrist.
10. DR. XXXX stated that she was accustomed to using a pain contract and doing a pain work-up. Also, She tried to have them come in for their refills. Sometimes she used a pain questionnaire. "If they come In requesting narcotics, they are telling me that their pain is severe." She didn't do drug testing, but she Does now.

C. ANNETTE XXXX

1. First office visit was 11/03/08. Although because the progress note stated "NO CHART," DR. XXXX Stated that she wasn't sure that this was her first visit.
2. DR. XXXX stated that the patient was depressed and she stopped her medications because she ran out of meds. Not suicidal. BP is never high. On exam she was "crying." "Lung and heart exam were normal." She was noted to have depression and OCD. Treated with PRISTIQ and asked to return in 1 week for BP Check.
3. Next visit was 4/9/09. Noted to be "morbidly obese, and history of gastric bypass surgery in the past. MS. XXXX suffered with severe chronic diarrhea and malabsorption. Dr. XXXX prescribed DONNATOL And WELLCHOL. She could not order LAB WORK or refer her to GI until MS. XXXX has insurance.
4. She saw her on 11/3 and asked her to come back in 4 weeks, but she came back in 5 months.
5. Next visit discussed was on 8/5/09. MS. XXXX claimed to have taken her mother's VICODIN and claimed That it helped her chronic diarrhea and back pain. She stated "No addictive history." DR. XXXX started Her on 3 VICODIN daily. "Long discussion regarding inappropriateness of this treatment. The patient has Tried multiple meds and has never exhibited addictive type behavior." No tobacco history, no alcoholic History, and no drug history. She took the VICODIN for her abdominal pain, no mention of back pain in Chart.
6. Next visit they discussed "possible internal Hemorrhoid for 3 years. Diarrhea is better." Hemorrhoids "are

Getting bigger." "No change, surgical referral." "Concerned with chronic narcotic use, not an addictive personality and patient's amount (# of tablets used) has not changed." "Refill with caution NORCO 2-3 a day." Given Anusol suppositories. VICODIN 7.5 #90.

7. Visit 2/23/10. She had been admitted with a infected PANNUS with ABSCESS. Heart and Lungs were clear And she had 2 plus pitting edema, Possibly due to IV fluid excess. Chronic diarrhea rule out COLITIS, CELIAC's disease, and she was referred to the county hospital. History of ANEMIA, check hemoglobin. Hospital records were requested and DR. XXXX prescribed LASIX. Patient refused LABWORK Due to lack of insurance and couldn't afford to pay for it.
8. Came in 3/2/10 with swelling and increased pain bilateral legs, desired pain meds." 'Pain is very bad." "No infection, but some erythema around small infected spots." DR. XXXX was given VICODIN #60.
9. March 29, 2012. Suffers with DEPRESSION, CHRONIC ABDOMINAL PAIN, INTRACTABLE DIARRHEA. Prescribed PAXIL 90, NORCO #90, PROVERA. Reviewed dates of prescriptions 3/10, 3/13, 3/17, 3/19, 3/29 NORCO #90 7.5/325 MG at each visit. DR. XXXX couldn't explain. MS. XXXX must have called in To the office for refills. Pharmacies were Walgreen's, Costco, Rite-Aid, and Savon.
10. DR. XXXX denied any knowledge of the refills. She didn't write the note on page 77, but she signed it.
11. Visit 9/2/10. Hemorrhoid bleeding, chronic diarrhea and was on TPN. Hospital records were requested. A note written in progress notes stated "husband controls." Meaning that her husband was dispensing it. She denied that the progress note was not her handwriting.
12. A nursing note stated "patient informed, needs to see GI." The date was 9/13/10. "Informed DR. XXXX Of patient's NORCO and PAXIL concerns." Patient stated that GI referral was too expensive. NORCO #120 Called in by JESSICA. "I am aware of her medication NORCO and how she is calling everyone in the office for it."
13. Visit 10/4/10. Chronic diarrhea, chronic abdominal pain, a physical exam, nothing unusual. Checked off Ear, HEENT, NECK, LUNGS, HEART, and she gave her a refill of NORCO #120, but concerned. Complaints of severe Abdominal Pain, Severe diarrhea and wearing a diarrhea. NORCO was giving her a quality of life.
14. Weight loss from 160 lbs to 137 lbs. She was described as malnourished. No previous use of opiates To treat anyone else's diarrhea. She has used non-controlled drugs to treat this patient's chronic diarrhea. The county system was going to reverse the bypass surgery.
15. Visit 11/8/10. She notes that she is seeing a GI specialist at MORENO VALLEY HOSPITAL. She is weaning Herself off of NORCO.
16. Visit dated 11/16/12, she was seeing the patient with nasal type congestion and followup. Assessment was Anxiety/Depression, malabsorption, questionable "I wrote Addiction." The patient denied "psychological Addiction." "She never appeared high to me" "She never appeared to be nodding off, she needed the medication to function." "I didn't diagnose her with addiction, I'm not an addictionologist .. . .I think I was questioning whether she was overusing."
17. MR. CCCC asked "What behaviors would you observe that would make you think somebody was, uh, addictive or addicted?" DR. XXXX responded "maybe the was that they appeared, the way that they were able to conduct themselves to me. You know, if they seemed foggy, or sleepy or, overly agitated, and requesting, you know, so much, so much, so much. "I can't think . . . I can't think of anything, I'm sorry." " I think I was questioning whether there was, uh, dependence." Yet DR. XXXX still filled NORCO #120. DR. XXXX stated that she did a psychiatry referral.
18. Visit January 3, 2011, DR. XXXX stated that she referred patient to a pain specialist. "Patient called stating that she was in the hospital and wanted NORCO refilled. Informed DR. XXXX . Patient to see a pain specialist DR.NNNN and to followup with GI." The patient called with Rectal Prolapse in severe pain and she was told to go to ER.
19. Visit January 5, 2011. Patient called complaining of a UTI. Patient called crying, in withdrawals." She hung When placed on hold.
20. Visit 2/16/11. Postop visit for rectal prolapse repair. Post fractured pelvis. She prescribed PRISTIQ and LAMICTAL First filled in the hospital. On 3/16/11 she was diagnosed with malnutrition, chronic pain, hypertension. The patient was given NORCO 10/325, which she had been getting in the hospital. DR. XXXX left that practice and this was the last note. The patient followed DR. XXXX to CORONA.
21. Visit 5/11/12 new office given refill for PAXIL, NORCO #90.
22. Visit 6/20/11 "Patient crying, begging for meds." The patient claimed that the hospital lost her prescription. "Needs narcotics for chronic diarrhea." "She says followed by GI." DR. XXXX claims that she knew How the narcotics help control her diarrhea and elevate her mood. Again she claims to have told patient That "it is not safe or appropriate to treat her problem." (with narcotics). She asked the patient to please find Another doctor. She wrote a new script for PERCOCET.
23. Seen in Urgent care by DR. XXXX . And seen on July 18, 2011 as well. Missing notes. Seen on July 28 For med refill. Low energy, chronic diarrhea, and depression, treated with Norco #150 and Percocet 10 mg. "Go find another doctor, I can't do this anymore." She went to the office manager and asked to have the Patient discharged. "When she is complaining of severe diarrhea and intractable abdominal pain, It is hard not to feel for her"
24. She did not believe that she was addicted. She believed she had severe abdominal pain. She stated on June 20, 2011, "her story today is that . . . she lost the medication." Which DR. XXXX stated was a "RED FLAG" for addiction being present. The patient stated "my patient is so severe, you've got to treat may pain,

I can't live like this, the cramping, the diarrhea, the chronicity, you know, the severity level." Despite Insisting on seeing the pain management doctor, the patient did not presumably due to cost.

25. Many excuses but no appointment. She had seen GI, and had seen a surgeon, and she had seen the Pain Management doctor, DR. NNNN. So by June 20th the patient was told that this was not the appropriate way to Be treated. On further questioning, DR. XXXX stated the use of NARCOTICS because "it absolutely allowed her to function. I did not want to continue being the person doing it." "I didn't want to, I was tired of her. I was tired of the begging and the crying. And I would feel so much compassion for her, and then I would feel I can't . . . I don't want to be involved in this . . . with this relationship. I want somebody else to take over. But yet I felt that it was the only treatment that worked for her. I can't explain."
26. As of June 20, DR. XXXX was frustrated, "it is the only thing that had worked, to wald around without a diaper. I mean she was on TPN. She is carrying an IV POLE. Getting vitamins, malnourished, severe pain. I . . . I can't describe it to you here, sitting at the table when it's like. Maybe it is appropriate. It might be off-label but it certainly had been done before. And . . .and . . .and for her it was appropriate in the sense that she was able to live."
27. Mr. CCCC asked her to explain why if it was working for her and that it was helping her function, why did she not want to do it, and why did she have to beg? "Because she was difficult, and it would be in the room for ½ an hour . . . and I couldn't do it." "I didn't want to be her doctor." DR. XXXX felt that she was being taken advantage of due to her compassion. But she didn't feel that the patient was abusing NORCO. "She was using to control pain and diarrhea." "She wasn't selling the drug." Again, DR. XXXX stated "I never saw her appear . . . high, inebriated, no . . . nodding off . . . never. She was always articulate. She was always clear headed.
28. MR. CCCC stated, "I also know patient uses narcotics to elevate her mood." Again, DR. XXXX stated, " I also know patient uses narcotics to elevate her mood." "And the request for early refills, that did not, uh, signal to you that she was abusing the drug?" DR. ZZZZ added, "were her symptoms getting worse?" Dr. XXXX responded, "yes." DR. ZZZZ asked "So this was a progressive thing?" DR. XXXX responded "Yes. I mean she would be on TPN for a short time, then it would become longer. Um, she was in and out of county hospital. . . absolutely was getting worse. Severe cramping paain, I mean, as you could imagine. I'm talking like 30 bouts of diarrhea . . .watery diarrhea per day. . . not even get out of bed and get to the restroom." DR. XXXX agreed with the statement that DR. ZZZZ stated "You felt that when she would request medications early, or she would request more or a highter dose, it was because it was getting worse and what she had before was no longer working."
29. As of August 30, 2011 DR. XXXX was continuing refills of #150 NORCO per month. "I felt that the work-up was complete. I didn't think I was missing anything. The diarrhea was due to the bypass. Yes I did. I did not feel that I was harming her. I was trying my best."
30 In October, 2011 , DR. XXXX started NEURONTIN. She referred her to GI surgery. She "continued NORCO. The patient was hysterically depressed." "She had severe intractable abdominal pain. Her pain Was real and severe." The last visit was 12/5/11, a post hospital visit. Dental antibiotics caused C. Dificile. Diarrhea didn't change. So after discharge she saw DR. XXXX with diarrhea and pain. Prescribed PERCOCET 3 per day. Discussed untreated BP. Asked to see PAIN specialty and GI consultant. DR. XXXX told her that she could no longer fill narcotics. DR. XXXX told staff that the patient needed to see DR. HAGAN. Visits ended at this point.
31. DR. ZZZZ asked DR. XXXX if she would have done anything differently in hindsight. DR. XXXX mentioned FENTANYL PATCH, and BUTRANS PATCH. When asked about why she needed to see a pain specialist she said just to take over care. DR. XXXX couldn't think of any other approach nor did she admit to reviewing the literature for alternative approaches to treatment.

VI. MEDICAL ISSUES IDENTIFIED

1. STANDARD OF MEDICAL CARE ISSUE.

QUESTION: Did the PAIN MANAGEMENT care provided by Dr. XXXX DDDD meet the medical standards expected of a practicing physician in the U.S. today?

A. Before beginning treatment with an opiate analgesic medication it is prudent to evaluate the chronic pain patient thoroughly before beginning therapy with potentially addictive and dangerous narcotic analgesic medications. The medical record should present the current status, past history and outline of planned therapy and future diagnostic evaluation. Many of the recommended parameters of care are listed in the guidelines discussed below.

STANDARD OF CARE:

The guidelines for the treatment of chronic pain with opioid and other controlled medications include:

1. All patients should have had a basic PAIN FOCUSED History and Physical. A pain focused medical history & physical examination must be accomplished in order to gather:
   A. HISTORY OF CONDITION:
      1. Onset of pain
      2. Assessment of pain, Pain control
      3. Duration

4. Triggers, causes
5. Association with other medical conditions,

B. Exact description
1. Location
2. Character of pain.
3. Severity of pain-
4. Measure of intensity of pain
5. Use of a visual analogue scale or equivalent 1-10 scale.

C. Baseline pain and functional assessment documentation & Degree of functional and physical
1. Assessment of physical and psychological function
ii. Evaluate Markers of neurological deficit and note other symptoms,
1. Bowel and bladder dysfunction,
2. Weight loss,
3. Fatigue,
4. Sleep disturbance,
5. Diminished physical or mental function
6. Other systemic complaints.
iii. Psychiatric history
1. Depression, Sadness
2. Suicidal ideation, Self Destructive Behavior
3. Mood swings, Emotional state
4. Marital issues, Family issues, Work issues,
5. Previous substance abuse, Alcoholism
6. Hallucinations,
7. Paranoia,
8. Delusions,
9. Anxiety, Panic, Stress

2. Assess the likelihood that the patient can be weaned from opioids in the event there is no improvement in pain and function.
3. Physicians should always inquire about a previous or current substance abuse history this is considered a basic requirement
4. A medication review and response to previous treatment
5. Documentation of the presence of recognized medical indications for use of a controlled Substance
6. Previous physician contact, exams, lab work, diagnostic studies, and specialty consultation.
7. Care and a review previous work-up
8. History of prior pain treatment and outcome
9. Relationship to current situation.
10. An assessment of underlying or coexisting diseases or conditions
11. Unclear diagnosis may require referral for one or more specialty consultations
12. Prior or current Litigation and prior or current work related injuries or accidents.
13. Chaotic home and psychosocial environment
14. Previous Substance or Alcohol abuse treatment programs
15. Allergies
16. Underlying or coexisting diseases or conditions.
17. Evaluation of the effect of pain on physical and psychological function

2. PHYSICAL EXAM FOCUSED ON AREAS OF CONCERN
A. WHAT ARE THE PAIN GENERATORS?)
B. What is the most likely reason for the patient's pain complaint.
C. Where is the Source of pain? This requires a thorough focused exam.
D. The Exam should match and correlates with medical history.
E. Patients are unable to determine their own diagnosis. Saying doesn't mean it's so.
F. A telephone conversation cannot provide the basis for an accurate diagnosis

3. Half of all patients in chronic pain suffer from 1 or more other medical conditions
A. There may be multiple or different diagnoses.
1. Prescribing opiate analgesics and other medications which may not be indicated in particular medical conditions, or which may affect end organ function must be discussed

4. Basic "Standard of Care" is that the physician or physician extender (Nurse Practitioner or Physician's Assistant) personally observe, interview, and examine the patient.

5. Often, during the interview the physician is able to quickly observe parameters that are not apparent in a telephone interview
    A. Inappropriate behavior,
    B. Current physical functional status,
    C. Personal hygiene,
    D. Psychological state,
    E. Physical and psychologic signs of
        1. possible drug abuse,
        2. psychiatric illness,
        3. emotional lability,
        4. character pathology,
        5. identity match with driver's license, and other
        6. psycho-social concerns.

6. Keep an accurate and complete medical record with thorough documentation at every visit for each chronic pain patient.

7. INFORMED CONSENT
    A. A discussion of risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver, or guardian

8. A written consent or pain agreement for chronic medication use, while not required, may make it easier for the physician to document patient education, the treatment plan, and informed consent.

9. Informed Consent and Agreement for treatment
    A. Discuss risks and benefits of the use of controlled substances
    B. The discussion should include all individuals who are involved in the patient's care and treatment.
        1. Patient.
        2. Surrogates
        3. Guardian.
        4. Other family, friends, parents, children, or care givers
    C. A written agreement between physician and patient outlining Patient responsibilities and expectations.

10. DIAGNOSTIC WORK-UP:

11. If the presumptive diagnosis requires further work-up and verification, the standard of care requires that the physician arrange for further
    A. Radiology exams,
    B. Neurological,
    C. Laboratory
    D. Specialized Testing

12. Work-up should include appropriate evaluation of end organ function. Major organ systems, such as liver, renal, cardiac, neurologic, gastrointestinal, or pulmonary have to be assessed both clinically and diagnostically via

13. ASSESSMENT:
    A. Once the physician feels comfortable with the presumptive diagnosis, regardless of whether further tests are necessary or not, then
    B. He or she should plan pain treatment in a step-wise fashion.
    C. The World Health Organization 3-step ladder is an excellent model to begin with
        1. The WHO suggest beginning with a non-opioid medication and
        2. Adding weaker opioids and/or an adjuvants if the first step is insufficient
        3. Incorporating longer acting, more potent opioid analgesics if pain continues

14. The treating physician should ask himself the following questions before a trial of opiates for chronic pain is indicated:
    A. Are their reasonable alternatives other than opioids? If so, what?
    B. Is the patient likely to improve with opioids?
        1. What is the expected time of treatment?
    C. Is the patient likely to abuse opioids or have other adverse outcomes?
        1. Is there a History of previous alcohol or drug abuse?
        2. Is there evidence of a psychiatric illness?
    D. Do I have the expertise to conduct a formal opioid trial for chronic pain?

1. If not, an appropriate referral should be made.

E. Does the patient suffer with other medical disorders or end organ dysfuntion
   1. May be a problem with opiate or combination-opiate tx for chronic pain?

Often, sources of chronic pain are misdiagnosed, even by specialists. Therefore, it is necessary for physicians who agree to care for patients in chronic pain, especially colleague physicians, to view every patient objectively. One must carefully re-evaluate the problem from a new perspective at the first visit/consultation, and periodically at each visit thereafter. That is why follow-up visits on medications is extremely important. Therefore, a history of failure of non-narcotic medication trials may be erroneous or perhaps were not assessed accurately. In other words, if the patient states that a medication or treatment doesn't work, the physician should not assume necessarily that this is true, it may be due to sub-therapeutic doses or lack of patient compliance, or other problems such as medication diversion or misuse. Also, over time, the tendency is for patients to forget how much pain they actually started out with and they may unknowingly re-set their sense of what their maximum pain levels are or were. This is something akin to what one sees when a pregnant woman forgets how painful it was to deliver her last child and chooses to become pregnant again despite vowing to "never do so again" at the delivery of her first child. Responses to patient retrial of medications can be different with different providers and different circumstances, so should always be reconsidered in new patients.

Based on the initial assessment, the treating physician creates a treatment plan and develops the initial objectives and expectations for treatment. With new patients, regular periodic review of patient treatment is necessary. It is not considered good medical practice to allow refills on controlled medications without a reassessment in person. Regular visits and re-evaluation of the situation are always necessary. It is prudent to see the opiate treated chronic pain patient or chronic sedative using individual once every 1 to 3 months. If an appointment is missed, opiate and controlled medications should not be refilled, regardless of excuse. Also, the prescribing physician should have discussed the risks and benefits of the use of controlled medications with the patient and have a signed medication agreement with the patient which spells out the requirements for continued use of controlled drugs.

15. Treatment Plan and Objectives
    A. Discuss Objectives by which the treatment plan can be evaluated and measured such as 1-10 VAS or Visual Analogue Scale to assess pain levels

16. Measurements of pain relief and/or improved physical and psychosocial function. Quality of life parameters.

17. Determine if any further diagnostic studies or consultations are recommended.

18. Consideration for other treatments or therapies planned and discussion of potential risks and Benefits expected.

19. Tailor pharmacologic therapy to the individual medical needs of each patient, always measuring risks and benefits.

20. Multiple treatment modalities and/or rehab program recommendations may be necessary if the pain is complex and associated with complicatied physical and psychosocial impairments.

21. SAMPLE PATIENT MEDICATION AGREEMENT (Should be present on each patient's chart)

PATIENT/PROVIDER
PRESCRIPTION/TREATMENT AGREEMENT

DATE:
PATIENT:
MEDICATION(s):
1._____
2._____
3._____

1. I promise that I will only receive my Controlled Medication(s) from a single provider, DR._____.

2. I will not seek potentially addictive or controlled medicine(s) from a dentist, the emergency room, or any other HealthCare Provider or source without my physician's express knowledge and consent.

3. I am required to have a primary care physician supervising my general medical care. I understand that DR_____ is a consultant in the specialty of Pain Medicine, and as such, my overall primary care must be supervised by my primary care physician.4. I will not sell, trade, share, or give my controlled medications to others. There is no reason or justification that is acceptable.

6. I will not engage in illegal activities to obtain or dispense addictive or controlled medications nor will I acquire illegal or "street" drugs. I understand that any Illegal activity will result in DR_____ terminating our Doctor/Patient relationship and that I will have to find another pain specialist as my physician and DR._____ will notify all involved physicians of my drug seeking behavior.

6. I will be responsible for keeping my potentially addictive medication out of the reach of children, pets, and others, and, there is no acceptable excuse if I lose or misplace my medication. If my medication is stolen, I will be required to complete a police report regarding the theft, and bring a copy to DR_____ before DR._____ will resume treatment with opiate medications. If the identity of the individual who took the medication is known, I will be required to report that individual to the proper authorities before DR._____ will resume treatment of my chronic pain condition. I understand that no excuses or reasons are acceptable.

7. I understand that taking my medication when using alcohol or other drugs could be extremely dangerous to my health. I will inform all of my healthcare providers about the medications and drugs that I am taking. I will not change the amount or dose of medication without informing my healthcare providers and DR._____ I take full responsibility for any accidents or incidents that occur while I am on my pain medications.

8. I understand that I should not drive an automobile or operate equipment or machinery while I am under the influence of medication(s).

9. I understand that my doctor has limited my use of these medications to a specific number of tablets per day, per week, or per month. I will not exceed this number unless DR._____ personally instructs me to do so. I am responsible for maintaining the limits prescribed. If I exceed the limits set, I understand that it is my responsibility to make an appointment with DR._____ at his earliest convenience to discuss the matter fully and consider changing the dose or consider the possibility of using alternative medications. If I run out of my medications early, I understand that DR._____ is not required to fill my prescription early.

10. It is my responsibility to notify my physician in a timely manner, at least 3 to 7 days prior to running out of my medication if I am asking for a refill to be arranged.

11. I must see DR._____ regularly to receive refills (at minimum once monthly). If I cancel my appointments or fail to come in for my regular consultations, I understand that NO medications will be refilled. No excuse will be accepted except for a phone call to DR_____ from my primary care physician notifying him of a special situation or emergency. My primary care physician will ultimately be responsible for supervising my general medical care.

12. Should my pain levels increase and I require physician reevaluation, I will make an appointment with DR._____ at his/her earliest convenience.

13. I understand that should I lose, misplace, damage, or accidently destroy my prescription DR._____ will not replace my medication(s). There is NO Reason or Explanation that is acceptable.

14. I Promise to bring ALL of my medications to every physician visit. If I fail to do so, I understand that Refills or new prescriptions may not be written. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours, Fridays, Holidays, or weekends. I will be responsible for leaving message(s) with an actual live person who works for DR._____, not a message recorder or the pharmacy. I understand that any medical treatment is initially a trial, and that continued prescription(s) with opiate analgesics are contingent on evidence of benefit.

15. If I have difficulty meeting the above responsibilities, or if other medical problems occur, I understand that I may need to attend clinic more frequently to pick up prescriptions that cover a shorter time period, or enter a drug treatment program for Detoxification and Rehabilitation. I will BBBB all Cost responsibilities due to insurance limitations on less than monthly quantities for prescriptions written by DR._____.

16. I am fully aware that by choosing to use potentially addictive medications to control my symptoms I may become physically dependent on these medications and may develop tolerance to them over time, in other words, I may be both physically and psychologically dependent on my medication(s).

17. I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed that I may experience painful withdrawal symptoms. This means I may develop any or all of the following initial symptoms of withdrawal: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability and psychological agitation, worsening of pain, musculoskeletal aches throughout my body, medication craving, and a severe generalized flu-like syndrome. I understand that If these symptoms become severe, I may have to be hospitalized.

18. I am aware that opiate withdrawal is uncomfortable but not usually life threatening. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia may be progressive and result in a lowering of my threshold to withstand pain. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opiates may cause my doctor to choose another form of treatment. Escalating the dose of opiate medications may not only lead to severe side effects, but may lead to death or coma due to respiratory and/or cardiovascular distress. Changes in end-organ function or addition of other medications may alter metabolism of my pain medications resulting in toxic serum levels.

19. (For Female Patients Only) If I plan to become pregnant or believe that I have become pregnant while taking this medicine, I will immediately inform DR._____. I am aware that, should I carry my pregnancy to delivery, whether full-term or premature while taking these medicines, my newborn infant will be physically dependent to this medication(s) and If this should happen, there is a possibility that my infant will need admission to the neonatal intensive care unit (NICU) for opiate or other medication withdrawal treatment. I am aware that the use of opiates is not generally associated with increased risk of birth defects. However, birth defects can occur whether or not the mother is on medications, and there is always the possibility that my child will have a birth defect while I am taking an opiate medication.

20. All controlled substances must be obtained at the same pharmacy, where possible. Mail order pharmacies, or 3 month insurance medication mail-in plans are never allowed. No excuses are acceptable.

21. DR. _____has my permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my healthcare for purposes of accountability and verification. If suspicions arise about my use of opiate and narcotic medications, I give DR. _____ permission to contact my spouse or other household relatives (adult children, parents, etc) to investigate the matter. My agreement to this request is required if DR._____is to provide opiate analgesic medications for my chronic pain condition.

22. Unannounced and monthly urine or serum toxicology screens (drug screening) WILL be requested at every visit, no exceptions, and your cooperation is required. Refusal to do or allow urine drug screening is grounds for DR._____ to discontinue opiate and controlled medication therapy for your pain condition. Presence of unauthorized substances may prompt referral for assessment for addictive disorder(s) and discontinuation of or tapering of your controlled medication.

23. I, _____suffer with intractable pain, and/or insomnia, and/or severe anxiety. I have had this problem for a long period and only this/these medication(s) in their current dosage regimen has allowed me to maintain acceptable function and given me a reasonable quality of life. I understand that there are other approaches to the treatment of chronic pain, insomnia, and/or anxiety, and I am exercising my right as an individual to choose this particular medical approach as long as DR. _____ agrees. I have a right, with DR._____'s permission, to the treatment of my intractable pain under California law and I do not wish to alter my current treatment regimen as long as DR._____ concurs with this approach to treatment.

24. DR._____ has recommended that my spouse and other significant members of my family (parents, children, siblings, and caretakers) be involved in my decision making. He has informed me that often family member may misunderstand the issues and choices that I have made and become upset when they learn about my decision to treat my medical condition with opiates/narcotics and other potentially addictive medications. It is my responsibility to discuss these concerns with my family. If there is a major disagreement from primary family members (spouse, parents, children, caretakers, etc.) then I must bring in family members to my next office visit. If I do not educate or include family members in this serious discussion with DR. _____, I understand that he may discontinue or change my medication therapy and medical

care. It is my responsibility to arrange for a family meeting, get appropriate medical consultation, or formally write letters asking my family to either get fully involved in my care, or to cease all interference. DR._____ believes that adequate pain management requires harmonious home environment and family support. Without this, pain management treatment will be quite difficult and of limited effectiveness.

25. I understand that the long-term effects of opiates on the brain, heart, kidneys, liver, and other organ systems may be detrimental to my health, and may cause organ system failure or dysfunction. The side effects and complications associated with medications in this class of drug have not been well studied or understood. Cardiac arrhythmias, elevated liver function testing, renal insufficiency, intestinal malfunction and severe constipation, gastric irritation and acid production, psychiatric disorders such as depression, psychosis, paranoia, dissociative disorders, insomnia, fatigue, emotional imbalance, and personality disorders, may complicate chronic opiate therapy. By agreeing to accept chronic opiate therapy to control and manage my chronic pain I have accepted the possibility that my health and longevity of life may be diminished.

26. I have read this form or have had it read to me. I understand all the requirements and responsibility of my pain management therapy. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my chronic pain and discomfort with the opiate pain and other potentially addictive medicine(s).

27. The following pharmacy will be the primary provider of my medications:

NAME:_____
ADDRESS:_____
TELEPHONE:_____
FAX:_____
STORE HOURS:_____

28. "I agree to follow these guidelines and I will read them carefully. If I cannot adhere to these guidelines, I will discuss any questions that I may have with DR._____ as soon as possible. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me."

29. Despite the fact that California allows individuals to obtain a "MARIJUANA CARD" in order to use MARIJUANA as a medicinal agent for certain medical conditions, DR._____ does not allow any patients under his care to use MARIJUANA while under his care.

If MARIJUANA truly resolves one's pain condition, then there is really no reason to seek treatment thru DR. _____. Unfortunately, the majority of MARIJUANA prescribing doctors have very little training in the treatment of pain and addiction, and do not provide ongoing pain management treatment. The Medical Board of California requires pain physicians to provide ongoing continuity of care, an extensive medical evaluation, and regular re-evaluation of the patient's medical condition in order to justify continued treatment with a controlled medication. Patients on MARIJUANA or most Opiate and other potentially addictive agents are unable to OBJECTIVELY measure the effectiveness of these agents over time due to the development of TOLERANCE, and only a trained physician who understands the complex issues involved in the treatment of PAIN & ADDICTION disorders may determine whether continued and ongoing treatment with MARIJUANA (THC) is effective and of benefit for the patient.

Like alcohol, MARIJUANA is an addictive agent and, to date, its pain and discomfort relieving effects are limited to a narrow list of medical conditions. Just as it is well known that alcohol may help lipid metabolism and relieve acute pain and insomnia, it is also well known that controlling alcohol ingestion, alcoholism, alcoholic liver disease, GI disorders, and drunk driving is such a huge public health problem, that physicians never formally prescribe alcohol to treat medical conditions.

Unlike prescription medications, smoking MARIJUANA exposes patients and their families to smoke inhalation, which is a potential carcinogen. MARIJUANA often builds up concentrations within the human body that may cause positive urine screens for 1 to 4 weeks post ceasing MARIJUANA use. Mixing it with other potentially addictive and dangerous pain, anxiety, and sleep agents is not well studied and may be detrimental to the long term health of the individual. Asthma, Emphysema, Lung and respiratory cancers and other disorders may be caused by primary exposure to the ill individual and by secondary exposure passively to family and friends residing in the same environment. Operating or driving an automobile under the influence of MARIJUANA mixed with pain medications, sedatives, sleep agents, muscle relaxers (ie. SOMA), and other pharmaceutical agents is extremely dangerous to the individual pain patient, their family, and to the general public.

"This agreement was entered into on this_____ day of_____ in the year_____. We Mutually Agree To The Above.

PATIENT NAME :_____

Signature of Patient:_____
(Signature should match CDL)

PROVIDER NAME:_____

Signature of Provider:_____

B. ANALYSIS: Review of the care provided DR. XXXX DDDD:

1. Review of the chart notes provided for her patients revealed inadequate chart notes and visit progress notes for visits with DR. XXXX . None of the notes provided sufficient information to justify the prescribing of controlled drugs like HYDROCODONE or OXYCODONE.

2. The basic approach to assess chronic pain and other disorders such as anxiety should be clear and apparent in the progress notes. While the Standards of Care as written in the medical board outline regarding the treatment of chronic pain are extensive, it is not expected that physicians will be able to include all of the issues that help physicians decide on a treatment approach using controlled medications at the first, second, or even the third visit, but the overall approach and analysis gives the physician a roadmap and clearly provide the data necessary to justify the treatment approach recommended by the treating doctor. This outlines future treatment in a few visits and provides as objective of a way of measuring treatment outcome as one can expect when dealing with a subjective disorder such as chronic pain, and this provides as accurate of an assessment as we can expect when measuring treatment progress, adverse effects, and pain control when treating chronic pain patients. The progress notes from the medical record should substantiate the presence of chronic pain, the level of intensity of pain, the quality of life expected with adequate treatment, and the optimal physical and psychological function expected with appropriate pain treatment.

   DR. XXXX 's office notes were inadequate at F/U visits to evaluate and assess pain treatment outcomes and to provide reasonable justification for continued use of controlled medications. In addition, there was insufficient discussion in the progress notes about chronic pain issues and inadequate reassessment of her patients treatment plan regarding the safest and most appropriate utilization of controlled medications regarding the decision to continue treatment of their pain conditions.

3. REVIEW OF DR. XXXX 's MEDICATION CONTRACT: The signed contract
   - #1. stated that "all controlled substances will come from physicians who signature appear below by the covering physician from Dr.XXXX 's office."
   - #2. "I will inform my physician of any current or past substance abuse by me or my immediate family." The Accuser's husband Mr. XXXX clearly has a history of substance abuse and was treated with SUBOXONE. In addition, DR. XXXX was treating MR. XXXX with opiate analgesics while being treated for addiction. Mixing SUBOXONE with OPIATES is inappropriate and the issue was never addressed.
   - #3. "I will inform Dr. XXXX of any new medications or medical conditions and any adverse experiences from medications and I take." Based on the number of physicians that have prescribed controlled drugs to her, there is no evidence that much of this information was transmitted to Dr. XXXX .
   - #7. "I will take my medication as prescribed and I will not exceed the maximum prescribed dose. " However, it appears to me that with all the extra prescriptions given to her from other physicians that Dr. XXXX did not address the increased number of prescriptions written by other providers.
   - #9. "I will cooperate with unannounced urine or serum toxicology screens as may be requested by Dr. XXXX ." I did not see any reports in the charts provided. Given all of the prescriptions written, one would expect at least several unannounced uring drug screens.
   - #12. "if I request a replacement for lost or stolen medication I may be discharged from the practice." Again, no mention or discussion in the progress notes. Given the large number of prescriptions written by other providers, she would be expected to discuss these issues in the progress notes.
   - #15. "I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by Dr. XXXX or referral for further specialty assessment." None of this appears to have been followed through with or considered. Progress notes did not provide any record of DR. XXXX addressing this issue.

#20. "I am aware that attempting to obtain a controlled substance under false pretenses is illegal." With all the prescriptions provided by other providers, I question whether Dr. XXXX was really aware of the other physicians involved and the prescriptions written by them.

C. CONCLUSION: Based on my review of the medical records provided and review of the C.U.R.E.S. DATA, in my opinion, there is an EXTREME DEPARTURE in the medical care provided to the patients treated by DR. XXXX as evidenced by inadequate medical records and progress notes to justify continued prescribing of controlled medications. There was no discussion or observations in the medical records that would provide justification for prescribing controlled medications to these patients. There was no discussion regarding alternative approaches to the treatment of pain or use of the myriad of non-addictive treatment approaches available for controlling pain. It is always a red flag when only addictive agents are offered for treatment. One should see the use of non-addictive available therapies mixed into the treatment plan in order to get the best possible outcomes when treating chronic pain. For example, muscle relaxers for muscle spasm, NSAIDS for inflammation, weaker pain medications like TRAMADOL or TYLENOL, and non-abusable anti-anxiety medications like BUSPAR and ZOLOFT. It is important for the treatment plan to make rational sense in regards to treating the "pain generators" directly and the reasoning behind the prescribed approach of therapy.

2. STANDARD OF MEDICAL CARE ISSUE.
QUESTION:
Should a physician treat an addict, with a mixture of mind altering and sedative medications such as HYDROCODONE and anti-anxiety medications and/or allow other physicians to prescribe addictive drugs?

A. STANDARD OF CARE: The following is quoted from an article by DAVID SACK, M.D. in ADDICTION RECOVERY "Some years ago a recovering addict with over five years clean and sober related to me a story about their doctor. They had been having some anxiety lately, and had been working on it through meditation, exercise, and nutrition, but still wanted the doctor to check if there might be something else contributing to what felt like sudden bursts of adrenalin: heart racing, sick feeling in the stomach, and shortness of breath. The doctor opined that it must be an anxiety attack."

"I'll write you a prescription for Xanax," the doctor told the patient. "Just take one when you feel an attack coming on." The recovering addict reminded the doctor that he is in recovery and cannot "just take one" when he feels like it. He would be taking "just one" all the time within a matter of days or weeks. The doctor's response was, "One pill isn't going to send you back to the Garden of Eden."

"Fortunately this recovering addict understood what his doctor did not. 'Just one' is not possible for those with addiction. Anyone who has ever been addicted to a drug is 10 times more likely to become addicted again than the general population. My friend declined the prescription and changed doctors."

When we hear about celebrities like Michael Jackson and Whitney Houston — people with a known history of substance abuse and stints in rehab — getting prescriptions for highly addictive drugs such as Xanax and Norco we wonder why anyone would even consider prescribing these medications.

However, as long as physicians do not truly understand addiction (that it is a brain disease) and we do not give them tools to intervene when patients are in trouble (treatment is getting harder to cover with insurance), this pattern will continue. We cannot keep beating the drums of blame without creating mechanisms for change.

Addiction is addiction. Where the drug is obtained, whether on the street or from the local pharmacy, and the reasons given as to why it's "needed," such as anxiety, or insomnia, or DIARRHEA, are really irrelevant once use has escalated to abuse."

B. ANALYSIS: DR. XXXX offered HYDROCODONE and OXYCODONE to MS. XXXX because she thought she was in distress. Essentially, in the case of MS. XXXX , DR. XXXX was offering treatment for what she diagnosed as "post intestinal bypass chronic diarrhea." DR. XXXX felt that the patient could not be treated with anything other than opioid analgesics. DR. XXXX argued in her progress notes that ONLY NORCO provided MS. XXXX with relief from chronic diarrhea and also that it made her feel better and that she had no other options but to prescribe OPIOID therapy. Since she was not sure about what she was treating, nor did she have enough background medical history, DR. XXXX kept insisting that MS. XXXX see a gastroenterologist and a psychiatrist. While the NORCO was refilled based on her belief and from a "well-meaning" perspective, that MS. XXXX 's chronic DIARRHEA, could only be treated with NORCO. What DR. XXXX did not understand was that MS. XXXX actually suffers from "OPIOID BOWEL SYNDROME," and that the opioids are not the indicated therapy. As DR. XXXX noted, MS. XXXX is an opiate addict, and therefore, DR. XXXX would have been expected to stop all OPIATES and not continue treatment with any OPIOID medications. DR. XXXX indicated that she "had no choice" and since the patient was "begging" & "crying" for opioid medications and DR. XXXX did not feel comfortable ignoring her requests for OPIATES.

C. CONCLUSION: DR. XXXX 's offer of NORCO & OPIOIDS to treat addicts, in order to treat her acute situation, while well-meaning, is considered an EXTREME DEPARTURE from the STANDARD OF CARE expected of a licensed physician in the U.S. today. Once a physician recognizes that the patient is an addict, it is imperative that the physician stop providing the addict with addictive agents.

3. STANDARD OF MEDICAL CARE ISSUE.
QUESTION: Was MS. XXXX 'S CHRONIC DIARHEA diagnosed accurately and treated appropriately?

A. The STANDARD OF CARE for CHRONIC OPIOID BOWEL SYNDROME and Bowel dysfunction, mainly constipation, is a well-known and anticipated side effect of opioid drugs. The physician prescribing an opioid frequently confronts the challenge of preventing and treating bowel dysfunction. Different strategies have emerged for managing opioid induced constipation. These strategies include physical activity, maintaining adequate fluid intake, adhering to regular daily bowel habits, using laxatives and other anti-constipation medications and, recently, using a peripheral opioid antagonist, either as a separate drug or in the form of an opioid agonist/antagonist combination pill. What options exist for the physician when a patient receiving opioids complains of diarrhea, cramps and bloating, rather than the expected constipation? This is seen when the patient becomes addicted to opiates and goes thru periods of constipation when on opiates and diarrhea when going through OPIOID withdrawal.

B. ANALYSIS: Clearly, Ms. XXXX is presenting with episodes of diarrhea and abdominal discomfort regularly and because of symptoms requests opioid medications to stop abdominal discomfort and recurrent diarrhea. However, individuals who are withdrawing from opioid drugs recurrently will suffer with recurrent episodes of diarrhea. MS XXXX clearly was addicted to opiates. She sought opioid therapy from multiple physicians and DR. XXXX did not recognize that MS. XXXX was addicted to opiates and she did not guide her toward appropriate treatment of her dependence on opiates. Even if she failed to recognize that the opiate withdrawal is the cause of recurrent diarrhea, DR. XXXX should have recognized that MS. XXXX was clearly OPIOID ADDICTED and that continued opioid THERAPY WAS INAPPROPRIATE.

C. CONCLUSION: [i]4. STANDARD OF MEDICisAL CARE ISSUE. QUESTION: DID DR. ALEGRIA MAINTAIN RECOMMENDED TREATMENT SAFEGUARDS AND COMPLY WITH STANDARDS OF APPROPRIATE MEDICAL CARE WHEN PRESCRIBING CONTROLLED MEDICATIONS TO ?

A. Standard of Care: upon initiating therapy with opioid analgesics and other controlled medications regularly, the medical record should indicate that safeguards for appropriate use and monitoring of these agents have been instituted. Not only should the progress notes describe the history and physical exam with attention paid to pain generators, past history, present history, assessment, diagnosis, diagnostic work-up, initiation of treatment, expectations of treatment, but also should provide ongoing regular discussion on outcomes of treatment analyzing the 4 A's: Analgesia, Activity and function, Affect and Attitude, Addiction risks,

1. A medication contract, while not mandatory, is a way of providing informed consent which spells out the guidelines involved when prescribing controlled medications like opiate analgesics and sleeping pills and other sedative medications. Although this is not a requirement, just a recommendation by the medical board, it is important to indicate exactly what the parameters of care are, and differentiate between the responsibilities of the physician and the responsibilities of the patient. Especially when the patient is a practicing physician.

2. Urine drug screens intermittantly. Although this is not a requirement, just a recommendation by the medical board, URINE drug screens help the physician to verify compliance of current therapy utilizing opiates and other controlled drugs such as sedatives and sleeping pills, and whether illicit drugs are being used or drug diversion is occurring unbeknownst to DR. XXXX .
3. UNIVERSAL PRECAUTIONS:

4.

5. Medical board guidelines discussed in previous questions.

B. ANALYSIS:

C. CONCLUSION: Based on the above observations, DR. XXXX 's interview, and the inadequate follow through regarding basic guidelines for the treatment of chronic pain and insomnia, in my opinion, there is evidence of an SIMPLE DEPARTURE from the standard of care for the treatment of who suffered with chronic pain, insomnia, and. While the actual quantity of medications is not in question, the approach to the treatment of is of concern.

5. STANDARD OF MEDICAL CARE ISSUE.
QUESTION:
WAS APPROPRIATELY EVALUATED FOR HER CHRONIC PAIN CONDITION AS RECOMMENDED UNDER THE MEDICAL BOARD OF CALIFORNIA GUIDELINES? AND WAS HER PAIN CONDITION TREATED

APPROPRIATELY?

A. Standard of Care: The standard of care for the long-term treatment of a chronic pain patient requires that the pain physician identify the underlying pain generators involved. Treatment of chronic pain requires that the physician create a differential diagnosis of possible causes of chronic pain. Once this has been done, then treatment should be directed at the underlying patho-physiology. Based on this analysis the choices of therapy can be tried and instituted.

B. Analysis:

1. ASSESSMENT OF PAIN

One of the main problems in assessing patients with chronic pain is that the physical examination and laboratory tests often do not provide the information necessary to gauge severity and assess outcomes. Various survey instruments and visual analogue scales that allow precise measurements of pain are available but used only rarely. Pain is generally assessed indirectly, which why it is so important to listen to--and believe--patients when they say that they are in pain. Unfortunately, unless there are more progress notes somewhere else, the progress notes provided by DR. XXXX do not show a significant work-up or assessment of 's pain condition by DR. XXXX .

1) *The patient's perception.* Asking the patient to keep a pain diary that includes numerical scales can help to objectify the pain.

2) *The patient's emotional state and somatic preoccupation.* This relates to the degree to which the patient remains focused on bodily symptoms to the exclusion of other issues and often can be best assessed by interviewing a close family member.

3) *Functional status at home.* The first things that many patients in pain stop doing are usually non-work-related activities such as going out with family and friends.

4) *Functional status at work.* The number of work days missed and the specific work activities curtailed because of pain are also useful indices of pain severity.

5) *Use of analgesic medications.* If the patient is given an adequate supply of effective short-acting rescue medications and told to take them as needed, the number consumed can be a measure of pain.

2. SETTING GOALS OF TREATMENT.

1) It is important that the physician and patient collaborate in developing the goals to guide treatment and the means to assess progress.

2) *Treating Suffering as Well as Pain.* The ultimate goal in treating chronic pain is for patients to reclaim control of their lives, and, to do that, they must be relieved of suffering as well as pain.

3) *OPIOID THERAPY.* Which drugs and quantities per month. Appropriate of choice and impact on chronic medical condition.

1) The vast majority of prescription opioid abuse or drug diversion cases investigated by the Drug Enforcement Administration, state medical boards, and other regulatory or law enforcement agencies involve short-acting opioids--sustained-release opioids are rarely a problem.

C. Conclusion: EXTREME DEPARTURE FROM THE STANDARD OF CARE due to inadequate explanation and reasoning regarding the alteration in medication management, inadequate differential diagnosis, and inadequate diagnostic work-up. The medical board guidelines clearly state that *"no physician and surgeon shall be subject to disciplinary action by the medical board for prescribing or administering controlled medications in the course of treatment of a individual suffering with "intractable pain. . . there is not a minimum or maximum number of medications which can be prescribed to the patient under either federal or California law.*

While he did receive opioid analgesics for his chronic pain situation,'s diagnostic work-up and pain evaluation are considered inadequate because of insufficient determination of the actual causes of 's chronic pain condition or

work-up for chronic insomnia. How can one treat 's primary pain problem without a firm diagnosis or follow-up evaluation for appropriateness of medical care.

VI. EVALUATION OF CHRONIC PAIN AND ANXIETY PATIENTS WHO REQUIRE OPIOID & ANTI-ANXIETY MEDICATIONS?

The progress notes and medical record should be presented in a manner that clearly describes the history and chief complaint, and justifies the initial treatment plan and diagnostic work-up. Unfortunately, the records were inadequate due to poor charting by DR. XXXX . The overall treatment plan and medications prescribed by DR. XXXX did not meet the medical board guidelines for the use of opiates and other controlled medications, and thus, 's medical care was considered grossly inadequate because the medical record did not show reasonable justification nor accurately portray the medical circumstances in which the therapeutic use of opioid analgesic medications and sedatives should be utilized.

The community standard is that physicians err on the side of "BELIEVING" the patient's account of the past medical history. Criminal Investigators on the other hand approach the medical history from a non-believing and skeptical viewpoint. This fundamental difference between law enforcement and the medical profession can be source of major misunderstandings. So it is incumbent on the investigator to remember that when medical providers are evaluated surreptitiously for inappropriate prescribing controlled medications, that this difference in approach be considered.

In addition, it is taught in medical school that when evaluating a patient "75% of the diagnosis is in the history and not the physical exam." Contrary to what the lay public and law enforcement believes, most well trained doctors diagnose medical problems while they are evaluating the history or story of current and historical events. Doctors are trained to begin their evaluation the moment that they encounter the patient upon walking into the exam room. Doctors notice how the patient presents themselves, the patient's posture, their gait, whether they are showing signs of drug withdrawal or over medication, whether they have pinpoint pupils or dilated pupils, pressured speech, disheveled appearance, skin abrasions or lesions, slurred speech, if they bend over to pick up something on the floor, their breathing patterns, whether they make other sounds such as grunting or sighing, their overall manner and demeanor, movement of extremities, and their verbal abilities, their dress, their affect, and their psychological and emotional state, and myriads of other factors. A hundred items can be assessed in a matter of seconds to minutes. Frequently the lay public misunderstands this approach to assessing medical problems, and that is why patients complain when the physician only spends "1 minute in the exam room." The physical exam for an acute problem is often more helpful than when dealing with a chronic long standing medical problem such as chronic back or musculo-skeletal pain. Pain is a "SUBJECTIVE" experience and what is considered painful to one individual may not be very painful to another. What one complains about and how they portray their pain are very important to the physician analyzing the issues of concern. Therefore, the history and story discussion and description is very important. The chronic pain patient who is ill informed or untrained can easily mislead a believing physician who places so much importance on a truthful history. The physician is not a police detective, he is not there to disprove or question the patient's portrayal of how they feel or what happened to them. Whatever is said is generally believed and used to analyze the medical issues at hand. I have seen many patients sitting comfortable discussing their painful condition nonchalantly swearing that it is 10/10 in intensity, or at maximum pain levels.

That being said, the community standard of care would find DR. XXXX 's PROGRESS NOTES in the medical records reviewed of 's office visits were inappropriate and inadequate based on the lack of substantiating records and portrayal of events. However, the items of concern, in my opinion, are that DR. XXXX did not consider the following in his treatment plan:

1. Few non-addictive or controlled medications were tried or utilized to treat 's chronic pain issues. He did not prescribe or try non addictive agents like SKELAXEIN, LIDODERM PATCH, LIDOCAINE CREAM, TRAZODONE, TRAMADOL, and TOPAMAX. But the primary emphasis was to use addictive agents and excessive amounts of sleep medications.

2. There was inadequate work-up for alternative pain generators and diagnosis.

3. No medication bottle checks or pill counts, prescription evidence, etc. Multiple episodes of early refills of PAIN MEDICATIONS.

4. No urine drug screens done to assess licit and illicit drug use.

7. No periodic review every 2 to 3 months to justify refills of sedatives and opiates.

The California guidelines indicate that the patient evaluation and treatment plan, informed consent, periodic reviews of the chronic pain condition, use of specialty consultations, and the necessity for maintaining accurate and complete medical records be part of the record keeping, treatment plan, and therapeutic approach to the treatment of the chronic pain patient.

According to the California State Medical Board Pain Treatment Guidelines, treating chronic intractable pain with OPIATE therapy can only be undertaken so long as the care provided is consistent with currently acceptable medical practices. The pain treatment guidelines were specifically created to address opiate therapy for acute pain, chronic pain associated with

cancer and other terminal diseases, or other chronic or intractable Non-Cancer pain related conditions, and the purpose of the guidelines is to assure the provision of effective medical treatment in accordance with recognized national standards and consistent with requirements to provide for the public health and safety.

Recognizing that no single approach to the treatment of pain with OPIATE medications is exclusively correct, there are certain essential factors that must be present when the treating physician is considering the option of beginning or continuing opiate therapy. Just because presented to DR. XXXX with a history of having already been on chronic opiate therapy and treatment for insomnia, previously started by a another provider, does not necessarily mean that there is justification for continued use of controlled medications, nor can it be assumed that the 's belief that it is the correct or best approach to treatment be considered necessarily accurate, in other words, cannot demand that DR. XXXX continue to provide opiates for pain treatment and sedatives and sleeping pills for insomnia. DR. XXXX must individually review, without bias,'s medical history and diagnostically evaluate her situation before coming to a conclusion about continuing or changing treatment using controlled medications.

Like all physicians, DR. XXXX should always view a colleague suffering with chronic pain and insomnia and presenting to his care as essentially a "clean slate." That is, regardless of what has been previously diagnosed and treated by other medical providers, it should not be assumed to be necessarily correct, accurate, or reasonable. Physicians who treat pain must keep an open mind and remember that mis-diagnosis is a common occurrence and therefore, patients who present to the office on opiate medication therapy deserve a re-evaluation of their current therapeutic regimen and the patient should be re-evaluated as though current therapy may be incorrect or based on the wrong pain generator(s). This approach adds objectivity to the evaluation process. By doing this, a provider like DR. XXXX is able to consider a complete differential diagnosis and offer a complete and thorough evaluation and, in turn, offer the best recommendations for treatment and, all possible therapies available. Interaction between doctor and colleague, especially one who is also his boss, is "not a negotiation" and physicians should not ask colleagues "what drugs do you need?" or have to justify why certain controlled drugs are off limits? The Doctor is the "captain of the ship," so to speak, and must be the guide and chief, and therefore, "the buck stops with DR. XXXX " when it comes to appropriate treatment and use of opioid and other controlled medications in 's case. In the end, it will always be DR. XXXX who is asked to provide evidence of how and why a specific approach to treatment was undertaken and DR. XXXX will have to explain the thought processes involved in the decisions that lead to's opioid and sedative therapy.

No drug urine analysis were reviewed or ever requested. Physicians who prescribe OPIOID and other controlled drugs should collect random and scheduled urine drug screens to determine if drugs previously prescribed are present, and if they are not present In the urine, determine whether diversion is a problem The treatment of chronic pain requires an ongoing effort by DR. XXXX to manage the chronic pain effectively, not just mask the pain. Measuring pain levels, pain intensity, functional abilities, and many other factors should be assessed at each visit and it is the analysis of these observations and measurements that help DR. XXXX understand and treat 's pain and/or insomnia malady effectively.

Using the California State Medical Board Guidelines to evaluate DR. XXXX 's' prescribing for pain and insomnia, the question is whether his approach to treating, a colleague, already on opiates and sedatives is considered reasonable and acceptable by the community standard? Is DR. XXXX 's treatment adequately described in the progress notes and medical records of considered clinically sound and in accordance with currently accepted medical practice guidelines regarding the treatment of pain, anxiety, and insomnia? The Medical Board makes it clear that no disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of controlled medications prescribed as long as there is adequate justification and they are prescribed in a safe schedule. It is the position of the medical board that opiates and sedatives may be prescribed, dispensed, or administered without fear of injudicious discipline when there is an indicated medical need. So, was there an "indicated medical need based on the records reviewed? The answer is NO.

According to the California State Medical Board, it is not the intent of the guidelines to define complete standards of acceptable medical care in the treatment of patients with pain and they the guidelines are not intended to direct clinical practice parameters. The intent is to give providers confidence that the guidelines are the standard by which opiate and sedative usage is evaluated.

There was no effort by DR. XXXX to thoroughly evaluate's pain and insomnia condition by considering:

1. A differential diagnosis and
2. Future diagnostic work-up and
3. Consideration for alternative therapies or treatment

These efforts, if present, should be evident in the progress notes and normally would be discussed with the Patient during the course of treatment, and they were no where to be found.

The California State Medical Guidelines indicate that continuation of opiate and insomnia therapy should be based on the provider's on-going re-evaluation of the:

1. Results of treatment, including the degree of pain relief;

2. Changes in psychological and emotional (functioning),
3. Changes in physical functioning, and
4. Changes in social functioning; and
5. Appropriate utilization of health services.

If DR. XXXX were unable to assess or evaluate these factors, the guidelines indicate that he is encouraged to obtain consultation from (specialty) providers who are knowledgeable in pain management and sleep medicine, particularly when managing a colleague, who is also his boss.

The California State Medical Board Guidelines emphasize that the goal of therapy is not merely to treat the symptoms of pain and insomnia but to devise pain management and sleep management strategies that deal effectively with all aspects of 's pain and insomnia syndrome, including his psychological, physical, social, and any work-related factors. In addition, written documentation in 's medical record should include:

1. A complete focused History and medical examination.
2. A complete focused physical examination focused on the source of pain generators and factors aggravating insomnia.
3. A comprehensive medical history should be part of the active treatment record with verification of previous diagnosis and therapy
4. A review of past pain treatment and insomnia therapeutic outcomes
5. Any history of addiction risks
6. A working diagnosis with a diagnostic and treatment plan.

The California Board Medical Guidelines indicate that the physicians should have working diagnosis which includes the presence of recognized medical indication(s) justifying the use of OPIATE and sedative medications along with any other treatment or medication recommendations being considered. DR. XXXX should include a clearly stated written treatment plan with recorded measurable objectives and there must be a record of previous and on-going discussion(s) with regarding these measurable objectives along with indication(s) that some thought had been made for future planned diagnostic evaluation(s) and analysis, and any recommended alternative treatments.

The written progress notes do not have to be extensively written notes, but may be as simple as this example note:

"I have discussed alternative therapies with the patient and he has already tried acupuncture, biofeedback, physical therapy, and NSAIDs without success." Measurable objectives can be as simple as "without opioid therapy, pain levels are 9-10/10, but with opioid therapy pain levels are 2-3/10 and the patient now enjoys his family activities and outings." "DR. _____ has returned to full time work since starting pain treatment and He tolerates the opioid analgesic drugs and there is no evidence of Abuse, Misuse, Diversion, or addictive behavior." In addition, he does not appear to be oversedated. I have discussed the fact that his reliance on LUNESTA, AMBIEN CR, and ZALEPLON is potentially dangeraous and may result In addiction and altered mental status, etc..

Committing the Patient to long-term chronic OPIATE and sedative therapy is a major decision, especially when the patient is a physician, and there are many potential future ramifications and potential complications regardless of whether a previous provider made the original decision to treat in this way or not. In other words, if long-term OPIATE and sedative therapy was originally based on:

1. Inadequate diagnostic evaluation,
2. Incorrect diagnosis,
3. inadequate alternative treatment trial(s),
4. Inadequate non-opiate and non-controlled medication trials,

It must be emphasized that continuing chronic OPIATE therapy is only a "band-aid" ultimately because in the end, only treating the symptoms of pain and insomnia will inevitably lead to develop TOLERANCE to the OPIATE sleeping medications which would mean that the same amount of OPIOID and SEDATIVE medication may no longer provide the same level of symptom relief for pain and insomnia as it once did due to the development of TOLERANCE. Hand-in-hand with the development of TOLERANCE there is the problem of HYPERALGESIA which is a problem that may occur despite regular treatment with OPIATES for the treatment of pain which results because despite continued use of the same quantity of pain medications the pain symptoms worsen beyond what would be expected with the development of tolerance alone.

The California State Guidelines indicate that Informed consent should include a discussion of risks and benefits of OPIATE and sedative therapy and it should be noted in some format in's medical record.

The Medical Board Guidelines indicate that at periodic reviews or office visits, DR. XXXX should have, if symptoms of pain INSOMNIA were not acceptably controlled, or there was a rapid increase in medication quantitites:

1. Re-assessed the treatment plan,

2. Re-assessed 's clinical course,
3. Re-assessed outcome goals with particular attention paid to
    a. disease progression,
    b. side effects, and
    c. emergence of new conditions.
4. Considered specialty Consultantion to help validate and verify the working diagnosis
5. re-evaluate the treatment plan utilizing alternative opiate and other controlled drugs
6. Should keep accurate and complete medical records documenting
    a. the dates of office visits, telephone calls, or after hour contact(s) and
    b. clinical findings for all evaluations, discussions and recommendations regarding diagnostic studies, lab work, specialty consultations, injections and other treatments,
    c. outcome(s) of use of non-opiate medications, and alternative therapies
    d. and any patient instructions and discussions.

Even if the final decision by DR. XXXX is to continue's OPIATE therapy, the medical records should substantiate the working diagnosis and discuss or justify why continuing OPIATE treatment is still the best approach for his colleague. Continued on-going medical assessment(s) and monitoring helps to avoid the risk(s) of developing Opiate Tolerance and Hyper-Algesia and avoid the problems associated with increasing opiate consumption without objective improvement in functional status and pain control.

Objective measures are determined by an ongoing "assessment and re-assessment"of 's:

1. Functional status
2. Ability to engage in work or other gainful activities,
3. Patient consumption of healthcare resources,
4. Positive or negative answers to specific questions about his pain intensity and its
5. Interference or enhancement of activities of daily living,
6. Quality of family life, hobbies, work, and social activities, and
7. Physical activity of the patient

In addition, physicians should not fear disciplinary action from the California State Medical Board or the DEA for prescribing, dispensing, or administering opiates when treating pain disorders, so long as the care provided is consistent with currently acceptable medical practices.

However, Physicians who decide to treat this very difficult and complex group of patients must acquaint themselves thoroughly with the recognized national standards in the field of pain treatment and to some degree, addiction medicine. The California State Medical Board Guidelines for the use of Opiate analgesic medications in the treatment of cancer and non-cancer related pain. The onus of responsibility for practicing physicians is to understand that it is estimated that 15-20 % of all individuals carry a genetic predisposition towards developing the disease of addiction, so that when we treat patients suffering with severe pain, it is incumbent upon the physician to recognize that an error in judgment during treatment may result in grave consequences for a particular individual. In addition, the physician also has a responsibility to their communities and the greater society in general to prevent diversion, misuse, and abuse of narcotic and other controlled analgesic medications.

Unfortunately, an error in carrying out this responsibility may result in grave consequences for the practicing physician as well. The Guidelines remind physicians to obtain appropriate consultation when they are unsure about proceeding with opiate analgesic therapy. In reviewing 's initial visits with DR. XXXX and the follow-up visits with him regarding his problems with chronic pain it is important to assess whether DR. XXXX had:

1. adequately evaluated the patient, and used good judgement in developing a treatment plan
2. addressed patient informed consent
3. practiced periodic clinical reviews
4. obtained or contemplated specialty consultation
5. kept and maintained complete and accurate medical records
6. developed a working diagnosis and maintained a differential diagnosis
7. offered alternative therapies and approaches to treating the disorder
8. reviewed previous medical records, diagnostic work-up, and medical therapy
9. assess for complications: dry mouth, constipation, urinary obstruction, respiratory depression, etc.
10. developed a plan of action for future diagnostic evaluation and
11. future plan of treatment
12. recorded objective measurements of pain levels, functional abilities, & Emotional and psychological status.

VII. SUMMARY,

In summary, based on my review of the data provided, it is my opinion that did not meet the requirements of the California State Medical Board Treatment Guidelines & Criteria set forth by the Medical Board of California. The recommended treatment and care of, a patient with a history of being treated with OPIATE medications for chronic PAIN AND SEDATIVES FOR INSOMNIA.

Review of's medical records should involve review of the progress notes of's medical record and involve a discussion about:

1. a current working differential diagnosis,
2. recommendations for future diagnostic tests and analysis,
3. evidence of having requested previous medical records,
4. acknowledegment of recent random urine drug screens showing the presence of prescribed medications or an explanation as to any discrepancies present.
5. in addition, on-going re-assessment of patient's medical history,
6. and evidence showing the continued presence of severe chronic pain and discomfort in order to justify the continued use of OPIATES, AND OTHER CONTROLLED MEDICATIONS.
7. with evidence of on-going re-evaluation at follow-up visits.

One can only conclude, based on the medical records reviewed that ALEGRIA did not adequately follow or meet the recommendations of the California State Medical Board Guidelines for the treatment of Chronic Pain with Opiate Medications and Insomnia with sedatives.

VIII. CONCLUSIONS:

Opiate medication addiction and dependence is at epidemic levels in the U.S. today, and therefore, physicians have a moral and ethical responsibility to recognize when patients, especially colleagues, have become addicted or dependent to doctor prescribed opiates and other controlled medications, and, in addition, to help them get appropriate treatment. Pain management approaches should always include consideration and discussion for non-addictive therapies and patients should be offered treatment with all available therapeutic modalities, including non-addictive medication management which should be part of any pain management treatment plan.

All physicians treating chronic pain must review the medical situation carefully, and treat the individual with a reasoned and thought out approach to treatment, which often means changing the previous therapeutic approach. The focus should be on identifying and localizing the correct pain generators and not on maintaining addictive behavior.

In addition, Patients on large doses of medications which might cause serious side effects and/or possible "end-organ" damage usually require evidence of initial and follow-up blood chemistries drawn in order to assess "end-organ" (liver, kidney, cardiac, etc.) baseline function before continuing potentially damaging medications, and to prevent drug over-dose due to slowed medication metabolism

Chronic pain treatment requires more than use of just opiate analgesic and other addictive medication(s) and, therefore, on chart review, one should see evidence of discussion of other therapies and other recommendations regarding behavioral therapy, psychological therapy and support, physical therapy, exercise, weight loss, and at least consideration of other modalities such as acupuncture, biofeedback, meditation, yoga, vitamin supplements, etc., and there should be plans for appropriate specialty consultation(s), diagnostic studies ie. X-Ray, Lab, Neuro-diagnostics, and drug screens to rule out illicit drug use or diversion, etc. Also, medication contracts or agreements should be present on each chart, and when promises are broken, there must be a discussion and ramifications instituted. The one paragraph medication contract was insufficient to spell out the guidelines and requirements for ongoing opioid therapy. Never-the-less, no consequences occurred.

Based on Medical Board Guidelines there should be an on-going dialogue in the chart about the condition(s) being treated, the differential diagnosis, the tests and procedures recommended, the prescriptions written, the consultants seen, previous medical records reviewed, and a discussion as to why the patient refuses to follow the physician's requests or orders.

Writing prescriptions without good reason or objective criteria is not how "good or adequate" medicine is practiced. Just because a patient insists on a particular medication or drug does not mean that the physician should agree with the request. In fact, if the patient insists on a particular brand or name of drug, this should be a "RED FLAG" or warning to the physician of the presence of a possible problem that could indicate medication misuse, abuse, or diversion. Treating pain is not a negotiation. Treating pain requires a well thought out approach to therapy, diagnostic work-up, and follow-up care. Since there is no way to predict who is genetically predisposed to the problem of drug addiction (estimated to be 15-20 % of the population), it is imperative that all patients be followed long-term in a coordinated objective fashion in order to justify continued use of Opiates and other medications. Cutting corners to save money usually ends with the patient not being monitored effectively and development of controlled drug abuse, misuse, or diversion

Physicians must follow the Hippocratic philosophy of "first, do no harm." Drug addiction, diversion, and misuse is an epidemic in the U.S.today, and physicians have a duty to ensure that the public is protected. Physicians know better than the lay public about how devastating opiate addiction is to our communities. While pain medicine must be available to those that really suffer with chronic pain, physicians must do everything possible to prevent medication misuse and diversion to the general public.

That being said, it is also impossible for physicians to control every potential "problem patient." If physicians carefully evaluate their patients and follow basic pain management guidelines the problems of opiate misuse can be minimized. In reviewing DR. XXXX 's C.U.R.E.S Reports, the controlled medications written for did not mirror his prescription record and thus seemed to be inappropriate for the most part.

IX. FINAL ANALYSIS:

In my opinion, presented himself to DR. XXXX as suffering from chronic pain and insomnia who requested controlled sedative medications/ Opiate analgesic medications for his chronic pain and insomnia condition. However, DR. XXXX did not offer any alternative therapies to treat his chronic condition despite the lack of any objective medical evidence that would justify the use of escalating opiate and sedative therapy. No diagnostic work-up was undertaken, no differential diagnosis was set forth, and no other records and diagnostic work-up was obtained or started. The medical board requirements state clearly that as long as physicians start a good faith effort to evaluate a chronic pain and insomnia patient, the treating physician should not fear disciplinary action. However, there was no effort to try other non-addictive medications, treatments, or to offer alternative modalities of therapy such as physical therapy, NSAIDS, muscle relaxers, local applications like Voltaren Gel or Lidoderm patch, nor any changes in sleep hygiene offered. The World Health Organization recommendations for pain treatment are that opiate analgesic treatment be limited to, and only offered after, failure to respond to routine non-opiate medications and other non-medication therapies. DR. XXXX did not order any labs to evaluate end-organ function nor did he do a diagnostic work-up, or refer him for consultation for rheumatologic disorders, and he failed to send his colleague, , to medical consultants specializing in chronic pain and sleep medicine.

The reasons for advising that the decisions involved in the medical care of represent an EXTREME DEPARTURE from the Standard of Acceptable Medical Care and Quality of care issues include:

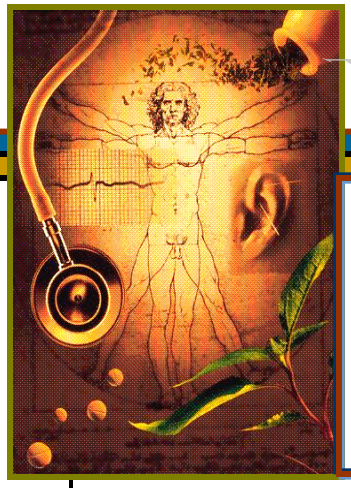
1. ABSENCE OF TREATMENT SAFEGUARDS COMPLYING WITH STANDARD OF CARE FOR PRESCRIBING CONTROLLED MEDICATIONS DURING LONG TERM OPIATE AND SEDATIVE THERAPY

2. INADEQUATE CHRONIC PAIN AND INSOMNIA EVALUATION AND TREATMENT originally in order to justify the Large amount of medications used in treatment without adequate explanation and progress notes justifying continued treatment..

Updated and Reviewed by: Rick Chavez M.D.

Date: 10/06/12
Rick Chavez, M.D.
Medical Director,
THE P.A.I.N. INSTITUTE
Pain & Addiction Integrated Network, Inc.
Medical Expert Reviewer for BMQA, State of California
Medical Expert Reviewer for DEA, Dept of Justice
Diplomate, American Academy of Pain Management
Board Certified, American Board of Family Medicine
Board Certified, American Board of Addiction Medicine (ABAM)
Board Certified, American Board of Pain Medicine (ABPM)
Former Assistant Clinical Professor of Family Medicine, UCLA David Geffen School of Medicine

[i]



THE P.A.I.N. INSTITUTE

Pain & Addiction Integrated Network, Inc

Rick Chavez, M.D.
Board Certified, American Board of Family Medicine
Board Certified, American Board of Pain Medicine
Board Certified, American Board of Addiction Medicine
510 North Prospect Avenue, Suite # 209
Redondo Beach, CA 90277
310 798-1633 (Office) 310 374-1576 (Fax)
www.PainAndAddiction.com

LIST OF PHYSICIANS REVIEWED BY DR. CHAVEZ ON BEHALF OF THE

1. MEDICAL BOARD OF CALIFORNIA,
2. DEA (Drug Enforcement Agency),
3. FBI (Federal Bureau of Investigation),
4. Attorney General of California, and the
5. Los Angeles County District Attorney.
6. Malpractice cases
7. Physician expert witness defense of physician regarding license revocation proceedings.
8. Multiple reviews for law firms REQUESTING MEDICAL OPINIONS.

All Names are currently part of the public record, but in those cases that are not, I have given names of legal representation and initials. Many I have been deposed on and have not listed all of the depositions and court appearances. I have given opinions on a wide variety of subjects. I am an expert in all clinical aspects and community standards of medical practice regarding FAMILY & GENERAL MEDICINE, ADDICTION MEDICINE both OUTPATIENT AND INPATIENT REHAB, PAIN MEDICINE & INDICATIONS FOR DIAGNOSTIC AND THERAPEUTIC INVASIVE PROCEDURES, OCCUPATIONAL MEDICINE, URGENT CARE, HOSPITAL CARE, OUTPATIENT MEDICINE, UTILIZATION REVIEW, MEDICAL BOARD OF CALIFORNIA PROCEEDINGS, AND DRUG ENFORCEMENT AGENCY (DEA) INVESTIGATIONS, including community standards for: physician / patient relationships and interactions, physician / employee relationships and interactions, physician / physician interactions and relationships, and physician self-treatment and drug use, etc.

I CAN BE SEEN IN A TELEVISION INTERVIEW ON YOUTUBE AT : http://youtu.be/g588W8d8uK4
Regarding the use of BUPRENORPHINE in treating opioid addiction.

1. DEA

Susannah Herkert, DI LAFD/Diversion Investigator RE: Masoud Bamdad, M.D. AKA: MASOUD BAMDAD FARROKH, M.D. LICENSE TYPE: Physician and Surgeon	03/03/2008	SENTENCED TO 25 YRS FEDERAL PRISON AS A A RESULT OF MY TESTIMONY IN COURT AS AN PHYSICIAN EXPERT WITNESS FOR THE DEA.

2. DEA
Susannah Herkert, DI 07/26/2007
LAFD/Diversion Investigator
RE: B YASSINE, M.D.
LICENSE TYPE: Physician and Surgeon

3. DEA
Spencer Shelton, DI 07/22/2007
LAFD/Diversion Investigator
RE: B. A. TAN, M.D.
LICENSE TYPE: Physician and Surgeon

4. MBC, TUSTIN District Office 01/22/2012
SENIOR INVESTIGATOR: Clinton D. Dicely, #361
SUPERVISING INVESTIGATOR I: James Kovash
DEPUTY ATTORNEY GENERAL: Matt Davis, Esq.
RE: A. U. RASHID, M.D.
CASE #: 04-2008-194927

5. MBC, CERRITOS
Senior investigator: Michael Buttitta #276 09/05/2003
Case Number: 06-2002-132578
RE: C. R. MCBRIDE, M.D.
LICENSE TYPE: Physician and Surgeon

6. MBC, TUSTIN DISTRICT OFFICE 08/06/2010
CASE #:04-2010-207017
INVESTIGATOR: ERIKA GEORGE #352
RE: W. J. MONTEGUT, M.D.
LICENSE TYPE: Physician and Surgeon

7. MBC
Senior Investigator: Paul Nasca, #287 3/08/2003
MBC: Internet Crime Specialist Unit
RE: S. F. SOOD, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 23-2002-132868

8. DEA
U.S. DOJ/ DRUG ENFORCEMENT ADMIN (DEA) 10/28/2010
DIVISION INVEST: SPEC AGENT KELLY WEBSTER
RE: N. A. BUSSAM, M.D.
LICENSE TYPE: Physician and Surgeon

9. DEA
U.S.DOJ DRUG ENFORCEMENT ADMIN (DEA)
DIVISION INVEST: SPEC AGENT MARK D. NOMADY 10/28/10 SENTENCED TO 11 YRS
RE: ALVIN YEE, M.D.
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: USC KECK SCHOOL OF MEDICINE

10. DEA
U.S. D.O.J. ADMINISTRATION (DEA)
DIVISION INVEST: SPEC AGENT ASIA A. WEBB 04/09/2011
RE: J. DIAZ, M.D.
LICENSE TYPE: Physician and Surgeon

11. DEA
U.S.D.O.J. DRUG ENFORCEMENT ADMINI (DEA)
DIVISION INVESTIGATOR: Sharon Harlig, DI 03/08/2008
LAFD/Diversion Investigator
RE: C. P. ESTIANDAN, M.D.
LICENSE: CA ACTIVE
DEA # Not available

12. DEA
USDOJ, DRUG ENFORCEMENT AGENCY (DEA)
DIVISION INVESTIGATOR: Susannah Herkert, DI 01/15/2007
SPECIAL AGENT: Mark D. Nomady
RE: V. LE, M.D.
LICENSE TYPE: Physician and Surgeon

13. DEA
U.S. D.O.J. DRUG ENFORCEMENT ADMINISTRATION (DEA)
DIVISION INVESTIGATOR: Susannah Herkert, DI 09/07/2009
LAFD/Diversion Investigator
RE: D. J. HEALY, M.D.
LICENSE TYPE: Physician and Surgeon

14. MBC, TUSTIN DISTRICT OFFICE
CASE #: 04-2010-206679
INVESTIGATOR: Clinton Dicely #361 06/28/2010
RE: L. M. TERESI, M.D.
LICENSE TYPE: Physician and Surgeon

15. MBC, CERRITOS
SENIOR INVESTIGATOR: Tracy Tu 10/08/2008
SUPERVISING INVESTIGATOR: Shoab Naqvi, M.D.
CASE #: 06 2006 179637
RE: T. M. LEE, M.D.
LICENSE TYPE: Physician and Surgeon

16. MEDICAL BOARD OF CALIFORNIA
Senior Investigator: Burton Villaverde, #249 02/20/2004
RE: G. F. YOUSSEF, M.D.
CA Medical License: # A42255
Case number: 18-2003-142160

17. MBC, VALENCIA DIST OFFICE
SENIOR INVESTIGATOR: Scott Vredenburgh #278 11/10/2007
SUPERVISING INVESTIGATOR I: Richard McSherry
CASE #: 05-2005-167939; CASE #: 05-2005-169631
RE: B. N. BASS, M.D.
LICENSE TYPE: Physician and Surgeon

18. MBC, SAN DIEGO DIST OFFICE
SENIOR INVESTIGATOR: Babette Luchaco #295 09/07/2008
SUPERVISING INVESTIGATOR: Nancy Edwards
SUBJECT INFORMATION: CASE #: 10-2006-175384
RE: J. KENAGA, M.D.
LICENSE TYPE: Physician and Surgeon

19. Medical Board of California Glendale District Office
Investigators: Jesus Gutierrez, #316-investigator; 09/06/2004
RE: E. P. WILLIAMS, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 23-2003-142527

20. MEDICAL BOARD OF CALIFORNIA
Senior Investigator: Roberta Terry, #269 03/24/2004
RE: H. A. JANUSZKA, M.D.
LICENSE TYPE: Physician and Surgeon

21. MBC, Cerritos 09/14/2004
Senior Investigator: Michael Buttitta, #276
Supervising Investigator: Marianne Eckhoff
RE: J. H. MERMAN, M.D.
Case: 06-2002 134593
Medical School: University of Miami, Florida
LICENSE TYPE: Physician and Surgeon

22. MBC, TUSTIN 02/25/2007
SENIOR INVESTIGATOR: Ernestina Cleland 02/25/2007
RE: J. J. MAGRANN , M.D.
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: California College of Medicine/UC Irvine College of Medicine 1961

23. MBC Internet Crime Specialist Unit, Sacramento
Senior Investigator: Paul Nasca, #287 09/20/2003
Supervising Investigator: Alberto Perez #293
RE: R. B. HASHEMIYOON, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 23-02-139959

24. Medical Board of California Internet Crime Specialist Unit
Senior Investigator: Paul Nasca, #287 09/20/2003
Supervising Investigator: Alberto Perez #293
RE: J. A. HENDLER, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 23-2 002-137917

25. MBC, Glendale
Senior Investigator: Jeff S. Ramos, #270 10/24/2004
RE: M. ASLAN, M.D.
Case: 05-2001-127859
LICENSE TYPE: Physician and Surgeon

26. MBC, Fresno District Office
SENIOR INVESTIGATOR: Gary L. Hudson #266 09/.25/2005
SUPERVISING INVESTIGATOR I: Brandon Pursell
CASE #: 08 2004 162429
RE: R. C. GAMBLE, M.D.
LICENSE TYPE: Physician and Surgeon

27. MBC, Cerritos,
INVESTIGATOR: Jaime Sandoval, 09/04/2004
CASE #: 19-2003-147904
RE: R. Z. BRAUN M.D.
LICENSE TYPE: Physician and Surgeon

28. MBC, LA-METRO PROBATION UNIT, CERRITOS,
LEAD INVESTIGATOR: JAIME SANDOVAL 08/14/2007
SUPERVISING INVESTIGATOR: JOHN HIRAI
Case 1E-2005-165274
RE: S. TURNIPSEED, P.A.

29. DEA
U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMINISTRATION (DEA)
TACTICAL DIVERSION GROUP SEATTLE FIELD DIVISION: ALASKA-IDAHO-OREGON-WASHINGTON
DIVISION INVESTIGATOR: THOMAS CLEMON, SA. TACTICAL DIVERSION SQUAD
RE: D. L. WHETSTONE, D.O.
LICENSE TYPE: Osteopathic Physician and Surgeon 11/10/2007
OSTEOPATHIC LICENSE: WASHINGTON STATE
MEDICAL SCHOOL: WESTERN UNIVERSITY HEALTH SCIENCES, COLLEGE OF OSTEOPATHIC MEDICINE OF THE PACIFIC

30. DEA
U.S. D.O.J. DRUG ENFORCEMENT ADMINISTRATION
INVESTIGATOR: Marc A. K. Marshall, Special Agent 06/13/2012
RE: A. SUN, M.D.
AKA: Andrew Suian On Sun, M.D.
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: Harvard Medical School

31. MEDICAL BOARD OF CALIFORNIA
DEPT. OF JUSTICE, ASSIST ATT. GEN: EDWARD KIM 09/12/2012
RE: Z. WEI LIN, M.D.
CASE #; 17-2010-210833
LICENSE TYPE: Physician and Surgeon

32. FBI
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF INVESTIGATION (FBI)
DRUG ENFORCEMENT ADMINISTRATION (DEA), ALBANY DIVISION.
DIVISION INVESTIGATOR: JULIE MOUNCE, Special FBI Agent 03/12/2011
RE: W. D. LONGMORE, M.D.
LICENSE TYPE: NEW YORK STATE MEDICAL BOARD LICENSE NUMBER: # 149851

33. LOS ANGELES COUNTY DISTRICT ATTORNEY
Deputy District Attorney: David Walgren, Esq., Major Crimes Div 04/10/2011
RE: CONRAD ROBERT MURRAY, M.D.
CA Medical Lic. #: G71169
MEDICAL SCHOOL: MEHARRY MEDICAL COLLEGE
CORONER CASE: 2009-04415 (DEATH OF MICHAEL JACKSON)
REPORT: ADDICTION MEDICINE SPECIALIST

34. MBC, VALENCIA District Office
Senior Investigator: Christopher A. Figueroa, Senior Investigator #324 05/29/2012
Supervising Investigator: John Hirai, Supervising Investigator
Deputy Attorney General: Edward Kim, Esq., Deputy Attorney General
Staff Physician Reviewer: Paul Zeltzer , M.D. District Medical Consultant
RE: W. "STANLEY" SU, M.D.
LICENSE TYPE: Physician and Surgeon

35. MBC, PLEASANT HILL DIVISION OFFICE
Senior Investigator: Dennis Scully, Senior Investigator #330 04/09/2011
Supervising Investigator: Teri Bennett, Supervising Investigator

DEP. Attorney General: Russell Lee, Esq., Deputy Attorney General
RE: A. BONSTEEL, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 12-2009-200652

36. MEDICAL BOARD OF CALIFORNIA, SAN DIMAS OFFICE
Senior Investigator: Johnny Tsang #356 02/ 21/2012
Supervising Investigator: Laura Gardhouse
Deputy Attorney General: Esther Kim, Esq.
RE: A. PASCALI, M.D.
LICENSE TYPE: Physician and Surgeon
Case No.: 11-2010-205307

37. MEDICAL BOARD OF CALIFORNIA, Tustin District Office
Senior Investigator: Clinton Dicely, Investigator #361, 11/17/2011
Supervising Investigator: James Kovash, Supervising Investigator #186
Deputy Attorney General: Randall Murphy, Esq., Deputy Attorney General
RE: D. A. SCHALLER, M.D.
LICENSE TYPE: Physician and Surgeon

38. MEDICAL BOARD OF CALIFORNIA, VALENCIA District Office
INVESTIGATOR: Rashya Henderson, Investigator #377 09/11/2012
INVESTIGATOR I: Julie Escat, Supervising Investigator I
DEPUTY ATTORNEY GENERAL: Tan Tran, Deputy Attorney General
RE: B. ONUBAH OKWUDILI, M.D.
CASE NO.: 05-2011-214515
LICENSE TYPE: Physician and Surgeon

39. MEDICAL BOARD OF CALIFORNIA, RANCHO CUCAMONGA OFFICE
Senior Investigator: Glenda E. Finley, Supervising Investigator I #241 12/21/2011
Supervising Investigator: Kathleen Nicholls, Supervising Investigator II
Deputy Attorney General: Chris Leong, Esq., Deputy Attorney General
Staff Physician Reviewer: Shoaib Navqi, M.D.
RE: H. HABTEZGHI, M.D.
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: MEHARRY MEDICAL COLLEGE, GRADUATED 1979

40. MBC, SAN BERNADINO DISTRICT OFFICE
SENIOR INVESTIGATOR: SHELLEE THORSON, #313, 09/01/2012
SUPERVISING INVESTIGATOR: STEVEN RICHTER
DEPUTY ATTORNEY GENERAL: SAMUEL HAMMOND, Esq.
RE: R. J. ALEGRIA, M.D.
CASE#: 09-2011-213576
LICENSE TYPE: Physician and Surgeon

41. MBC, TUSTIN DIST. OFFICE
INVESTIGATOR: CLINTON DICELY 06/10/2011
RE: T. LYNCH, M.D.
CASE#: 04-2010-207537
CORONER REPORT: 10-03108-RL
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: PONCE SCHOOL OF MEDICINE, PUERTO RICO.

42. MEDICAL BOARD OF CALIFORNIA, Probation Unit
Probation Inspector: Verdeena Richardson 06/12/2012
MEDICAL EVALUATION

RE: R. MITCHELL KARNS, M.D.
LICENSE TYPE: Physician and Surgeon
CASE: #17-2011-215473

43. MBC, SAN BERNADINO DIST. OFFICE
SENIOR INVESTIGATOR: NATALIE ZELLMER #253, 11/01/2012
SUPERVISING INVESTIGATOR: STEVEN RICHTER
DEPUTY ATTORNEY GENERAL: MICHAEL COCHRANE, ESQ.,
RE: Z. BENJAMIN, M.D.
CASE#: 09-2011-213167
LICENSE TYPE: Physician and Surgeon

44. MBC, PLEASANT HILL OFFICE
SENIOR INVESTIGATOR: LINDSAY BREARLEY, #349 09/11/2012
SUPERVISING INVESTIGATOR: TERI BENNETT
MEDICAL BOARD CONSULTING MD: MARTHA SNIDER, M.D.
DEPUTY ATTORNEY GENERAL: RUSSELL LEE, ESQ.
RE: M. R. CHIAROTTINO, M.D.
CASE#: 12-2011-217990

45. MBC, GLENDALE DIST OFFICE
SENIOR INVESTIGATOR: ROBIN HOLLIS, #235 7/11/2012
SUPERVISING INVESTIGATOR: JEFF GOMEZ
DEPUTY ATTORNEY GENERAL: WENDY WILDUS, Esq.
RE: R. G. ORAVEC, D.O.
CA LICENSE: 20A7730 OSTEOPATHIC PHYSICIAN & SURGEON

46. OSTEOPATHIC PHYSICIAN & SURGEON, TUSTIN Distirict Office
INVESTIGATOR: Clinton Dicely, Investigator #361 12/09/2009
RE: W. A. LILLY, D.O.
MBC CASE #: 06-2009-002486
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: UNIVERSITY OF HEALTH SCIENCES 09/74-06/79

47. MEDICAL BOARD OF CALIFORNIA, PLEASANT HILL DISTRICT OFFICE
INVESTIGATOR: NOELLE HOLLOWAY, Senior Investigator #206 10/09/09
RE: A. KUGEL, M.D.
DOB: 07/23/1947
MBC CASE #: 12-2008-190253
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: Loma Linda medical school

48. MEDICAL BOARD OF CALIFORNIA, CERRITOS DIST. OFFICE 09/7/2009
INVESTIGATOR: SYLVIA SALCEDO, Senior Investigator #245
RE: B. POWELL M.D.
MBC CASE #: 06-2008-190763
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: HOWARD UNIVERSITY SCHOOL OF MEDICINE

49. MEDICAL BOARD OF CALIFORNIA, FRESNO DIST OFFICE
INVESTIGATOR: TODD BAKER, Senior Investigator 03/31/2009
RE: J. R. HARDMAN M.D.
MBC CASE #: 08 2006 179623
LICENSE TYPE: Physician and Surgeon
MEDICAL SCHOOL: ROSS University School of Medicine, Caribbean Island; 2003

50. OSTEOPATHIC PHYSICIAN & SURGEON, CERRITOS DIST. OFFICE 06/08/2009

Investigator: Jeff Gomez
RE: H. A. WINKLER, M.D.
CA LICENSE # A50311
LICENSE TYPE: Physician and Surgeon
CASE: 06-2006-172967

51. MBC, SAN JOSE DIST OFFICE
SUPERVISING INVESTIGATOR: VICTOR SANDOVAL #326 08/09/2010
DEPUTY ATT GEN: KERRY WEISEL ESQ.
RE: G FELDMAN, M.D.
LICENSE TYPE: Physician and Surgeon
CASE: 03-2010-208147

52. MBC, PLEASANT HILL DIST OFFICE
SENIOR INVESTIGATOR: NOELLE HOLLOWAY #206 09/09/2009
DEP. ATT. GEN: RUSSELL LEE, ESQ
RE: L SHAVELSON, M.D.
LICENSE TYPE: Physician and Surgeon
MED SCHOOL: UCSF SCHOOL OF MEDICINE
CASE : 12-2010-210891

53. MBC, RANCHO CUCAMONGA DIST OFFICE 04/10/2010
SENIOR INVEST: GLENDA FINLEY #241
DEP ATT GEN: LORI FORCUCCI, Esq.
RE: K DO, M.D.
LICENSE TYPE: Physician and Surgeon

54. MBC, PLEASANT HILL DIST. OFFICE 05/11/2011
SENIOR INVESTIG: AARON ADICOFF, #389
DEP ATT GEN: KERRY WEISEL, ESQ.
RE: J P HIBBARD, M.D.
LICENSE TYPE: Physician and Surgeon
CASE: 12-2009-202794

55. MBC 09/09/2011
SENIOR INVEST: BURTON VILLAVERDE #249
RE: J ACEVES, M.D.
LICENSE TYPE: Physician and Surgeon
CASE: 18-2003-149407

56. MBC, TUSTIN 07/13/2013
SENIOR INVEST: JEROME HULL #361
RE: V HUY VU, M.D.
LICENSE TYPE: Physician and Surgeon

57. MBC 07/25/2013
SENIOR INVEST: AARON BARNETT
RE: M.W.L, M.D.
LICENSE TYPE: Physician and Surgeon
CASE: 02-2011-21XXXX

58., DEA 04/7/2013
SENIOR INVEST: NIKOLOUDAKIS
CASE: CASE # 04-2012-221998 G. BORAZJANI, M.D., ET AL.

A. RE: G BORAZJANI, M.D.
LICENSE TYPE: Physician and Surgeon
B. RE: D NIKNIA, PA-C

LICENSE TYPE: Physician Assistant

C. RE: L. M. FLORES, M.D.
LICENSE TYPE: Physician and Surgeon

D. RE: HOSSEINGHOLI IAEE, M.D.
LICENSE TYPE: Physician and Surgeon

E. RE: A.K. AMIR-JATHEYD, M.D. (LICENSE SURRENDERED)
LICENSE TYPE: Physician and Surgeon

F. RE: K GOHAR, M.D. (DECEASED)
LICENSE TYPE: Physician and Surgeon (DECEASED)

G. RE: J M GARFINKEL, M.D. DECEASED
LICENSE TYPE: Physician and Surgeon

H. RE: L GULAPA GATUS, M.D.
LICENSE TYPE: Physician and Surgeon

I. RE: PAUL M. ROBINSON, M.D.
LICENSE TYPE: Physician and Surgeon

J. RE: BAHRAM TABIBIAN, M.D.
LICENSE TYPE: Physician and Surgeon

RE: L.A. GENERAL PAIN MANAGEMENT CLINIC & OUTPATIENT DETOX CENTER.

1. KEVIN GOHAR, M.D. DECEASED
2. LUIS FLORES, M.D.
3. LEANDRO GATUS, M.D.
4. BAHRAM TABIBIAN, M.D.
5, PAUL L. ROBINSON M.D.
6. SEAN BALAKHANI, D.C.
7. FARZAD FARAHMAND, D.C.

69. MBC ORIGINAL COMPLETED 3/2013
VCONTRERAS, M.D.
INVESTIGATOR : AMBER DRISCOLL #379
SUPERVISING INVESTIGATOR: RUSSELL CHEE
DAG: EDWARD KIM ESQ., DEPUTY ATTORNEY GENERAL
TUSTIN DISTRICT OFFICE
CASE: 04-2012-221XXX

60. MBC RE-EVALUATION COMPLETED 10/15/2013
V CONTRERAS, M.D.
INVESTIGATOR: AMBER DRISCOLL #379
SUPERVISOR: RUSSEL CHEE
DAG: EDWARD KIM, ESQ., DEPUTY ATTORNEY GENERAL

61. MBC COPLETED JULY 2013
P ANTONY BEORIS, M.D.
SENIOR MEDICAL BOARD INVESTIGATOR: ROBERT MOYA, #309
SUPERVISING INVESTIGATOR: MARK LOOMIS,
DAG: MIA PEREZ, ESQ., DEPUTY ATTORNEY GENERAL
CASE#: 19-2011-214XXX

62. PARKER, MILLIKEN, CLARK, O'HARA, & SAMUELIAN, A PROF. CORP. 555 SOUTH FLOWER ST, 30 TH FLOOR, LOS ANGELES, CA 90071. RICHARD CLARK, ESQ. LAWSUIT BY M.L. AGAINST NOVARTIS PHARMACEUTICALS DEPOSITION FOR DEFENDANT, NOVARTIS PHARMA. SEPTEMBER 2013

63. LAW FIRM OF GERAGOS & GERAGOS, LLP. I PROVIDED LEGAL EXPERTISE DEFENDING A PHYSICIAN

THREATENED WITH REVOCATION OF HIS MEDICA LICENSE FOLLOWED BY PROBATION IN ORDER TO PRACTICE MEDICINE IN THE STATE OF CALIFORNIA, AND THIS ACCUSATION WAS BROUGHT TO BEAR BY THE MEDICAL BOARD OF CALIFORNIA. AS PART OF MY TESTIMONY REQUIRED TO DEFEND THIS PHYSICIAN, I WAS REQUIRED TO PRESENT AND DISCUSS MULTIPLE COMPLEX ISSUES BASED ON MY EVALUATION OF HIS HANDWRITTEN CHART PROGRESS NOTES AND I REVIEWED THE MEDICAL BOARD EXPERT WITNESS TESTIMONY WHICH HAD OCCURRED EARLIER IN THE COURT PROCEEDINGS.

THE EXPERTS WHO PRESENTED COUNTER ARGUMENTS WERE A PROFESSOR OF NEUROLOGY WHO HAS WRITTEN SEVERAL BOOKS, AND A CLINICAL PROFESSOR OF FAMILY MEDICINE WHO IS THE CLINICAL DIRECTOR OF A FAMILY MEDICINE PROGRAM.

AFTER MY COURTROOM TESTIMONY, THE ASSISTANT ATTORNEY GENERAL DECLINED TO CROSS EXAMINE ME AND REQUESTED THAT THE COURT POSTPONE THE TRIAL 4 TO 6 MONTHS, AT WHICH TIME THEY MAY CROSS EXAMINE ME. ACCORDING TO THE DEFENSE, THIS WAS AN UNUSUAL OUTCOME, AND MAY INDICATE THAT AFTER REFUSING TO SETTLE THE CASE PRIOR TO MY TESTIMONY THAT THE MEDICAL BOARD AND THE ASSISTANT ATTORNEY GENERAL MAY HAVE CHANGED THEIR MINDS AND MAY NOW DESIRE TO SETTLE THE CASE IN FAVOR OF THE DEFENDANT PHYSICIAN.
CASE IS PENDING OCTOBER 2013.

64. LAW OFFICES OF CARROLL, KELLY, TROTTER, FRANZEN, & MCKENNA, OFFICES IN SAN DIEGO, LONG BEACH, & HENDERSON, NEVADA. ASKED TO REVIEW HOSPITAL AND MEDICAL RECORDS FOR MATTHEW TROTTER, ESQ. CLIENT *H.C.* VERSUS *B.S. M.D*. THE CASE WAS SETTLED FIRST WEEK OF NOVEMBER, 2013

66. HAGOOD & NEUMANN, ATTORNEYS AT LAW. 1520 E. HIGHWAY 6, ALVIN, TEXAS. REPRESENTING A.M.F. & HER HUSBAND S.P.F. VERSUS C.A. M.D. AFTER MY INITIAL EVALUATION OF 3 VOLUMES OF MEDICAL RECORDS AND AN ORAL DISCUSSION OF MY FINDINGS, I HAVE BEEN RETAINED TO WRITE A FORMAL REPORT REGARDING MY OPINION OF THE MEDICAL CARE PROVIDED TO A.M.F. BY THE DEFENDANT PHYSICIAN.
CASE IS PENDING.

67. W.W. VERSUS OUTDOOR RESORTS, INC. LAW OFFICES OF SAYRE & LEVITT, LLP. 900 N. BROADWAY, 3 RD FLOOR, SANTA ANA, CA 92701. TEL: (710)550-9117. FREDERICO CASTELAN SAYRE, ESQ. WW. WAS IN A GOLF CART THAT WAS STRUCK BY A TRUCK DRIVEN BY GARDENERS WHO WORKED FOR THE GOLF COURSE. I WAS DEPOSED REGARDING WW's ACCIDENT MEDICAL CLAIMS AND MY MEDICAL FINDINGS BASED ON MY EXPERTISE IN THE AREA OF CHRONIC PAIN MANAGEMENT. CASE SETTLED FOR AN UNDISCLOSED AMOUNT. WW. APPARENTLY WAS SATISFIED. CASE SETTLED.

68. AMERICAN MEDICAL FORENSIC SPECIALISTS ASKED ME TO REVIEW A CASE REGARDING A PATIENT WHO SUFFERED SIDE EFFECTS FROM BOTOX TREATMENT. I REVIEWED THE CASE AND RENDERED AN OPINION.

69 AMERICAN MEDICAL FORENSIC SPECIALISTS ASKED ME TO REVIEW A CASE OF AN ELDERLY LADY WHO SUFFERED A MEDICAL COMPLICATION AFTER A TRIGGER POINT INJECTION IN ARIZONA. SHE DEVELOPED A PNEUMOTHORAX AND I WAS ASKED TO REVIEW THE CASE TO DETERMINE IF ADEQUATE INFORMED CONSENT HAD OCCURRED AND TO REVIEW WHETHER THE PROCEDURE WAS DONE COMPETENTLY AND CONSIDERED ACCEPTABLE BY COMMUNITY STANDARDS..

AMERICAN MEDICAL FORENSIC SPECIALISTS
6 CASES
1. J.H. PATIENT 09/20/2010; BJB, M.D.
2. J.M. PATIENT 10/14/2011
3. D.M.W. PATIENT 09/13/10
4. M.K PATIENT 11/11/11
5. M.S. PATIENT 11/12/11
6. K.R. PATIENT 11/15/11
7. ST VS MCF 04/09/10

70. IN 1989 I TESTIFIED IN A MEDICAL MALPRACTICE CASE FOR A LOCAL SURGEON REGARDING PRE AND POST OPERATIVE MEDICAL CARE. THE SURGEON WAS FOUND NOT TO BE AT FAULT.

71. IN 1985 I TESTIFIED ON BEHALF OF TODD PACIFIC SHIPYARD, INC. IN COURT REGARDING THE PSYCHIATRIC COMPETENCY OF AN EMPLOYEE AND HIS FITNESS TO RETURN TO WORK. THE EMPLOYEE WAS FOUND TO BE PSYCHIATRICALLY INCOMPETENT AND WAS NOT ALLOWED TO RETURN TO WORK UNTIL RELEASED BY A TREATING PSYCHIATRIST.

UP TO EARLY 2013.

13 DEA + 48 MBC + 1 DA + 1 FBI + 7 LAW FIRM REQUESTS + 8 AMERICAN FORENSIC SPECIALIST CASE REVIEWS = 76 TOTAL CASES TO DATE.

REVIEWED BY:
RICK CHAVEZ, M.D.
The P.A.I.N. Institute
510 North Prospect Avenue, Suite# 209
Redondo Beach, CA 90277
Phone: 310.798.1633; Cell: 323-228-8388; Cell: 323-833-8269; Fax: 310.374.1576
email: RickChavezMD@aol.com; email: PAINandADDICTION@live.com
web: www.PainAndAddiction.com

AS SEEN IN
southbay
health

THE P.A.I.N. INSTITUTE

✉ 510 N. Prospect Ave., Suite 209,
in Redondo Beach
☎ 310-798-1633
painandaddiction.com

RICK CHAVEZ, MD,
MEDICAL DIRECTOR
LYNETTE PRUCHA,
ADMINISTRATIVE DIRECTOR

VITALS

EDUCATION:
BA in psychology, Stanford University; MD, UCLA David Geffen School of Medicine; residency, Harbor-UCLA/SPPH Joint Family Medicine Program; board-certified, American Board Of Family Medicine, American Board Of Pain Medicine and American Board Of Addiction Medicine; former medical director for five years, San Pedro Peninsula Hospital Chronic Pain Program; former medical director, Todd Pacific Shipyards Occupational Medical Clinic

AWARDS & ACCOLADES:
Member of American Academy of Pain Management, American Society of Addiction Medicine, LA County Medical Assoc., AMA, CMA, California Society of Addiction Medicine, Independent Consultant to the DEA, Attorney General of California & Medical Board of California, former assistant professor of family medicine, UCLA School of Medicine

HOSPITAL AFFILIATION:
Torrance Memorial Medical Center, Providence/Little Company of Mary Hospital

SERVICES OFFERED:
Pain medicine and management; addiction treatment—outpatient medical management; expert/patient advocate/second opinion to verify need for surgery or discussing all options of care available; expert at determination of all options and alternative approaches to surgery; patient advocate for individuals regarding most medical issues

For consultations or appointment requests, e-mail requests to PainandAddiction@live.com.

> *"Our treatment plans are customized to meet the physical, emotional and spiritual needs of each patient—providing care and addressing most conditions in a healing, relaxing and comfortable environment."*

CAREER MILESTONE

I originally envisioned a new and unique program in which I would become the patient's "personal guide and advocate" as they journeyed through the very complex issues related to the diagnosis and treatment of chronic pain and the difficult problems caused by alcohol and drug addiction, along with the growing problems related to the long-term use of doctor-prescribed opioid pain medications. The P.A.I.N. Institute (Pain & Addiction Integrated Network, Inc.) was created after I had completed two years as assistant medical director for Ambulatory Care Services at Health Care Partners Medical Group in 2002. I recognized through my work with HCP, and as a board member and one of the medical directors with the medical foundation of Little Company Of Mary Physicians Medical Group, that there was a tremendous need in the South Bay community for a "Center of Medical Excellence" emphasizing the comprehensive evaluation, treatment and management of all disorders and conditions related to the two highly specialized and challenging fields of pain and addiction medicine. Pain and addiction are insidious and affect greater than one in three Americans and cross virtually every specialty of medicine. Our treatment plans are customized to meet the physical, emotional and spiritual needs of each patient—providing care and addressing most conditions in a healing, relaxing and comfortable environment.

RECOMMENDED

If you find yourself trying to desperately break the cycle of "doctor-prescribed opiate medications," you need not go through an inpatient rehab program. Chronic pain does not mean that you are an addict! Buprenorphine outpatient detox from doctor-prescribed opioid medications breaks the misery and cycle of this disorder.

PRACTICE SPECIALTY

Determining sources or causes of pain and identifying actual pain generators. Patient advocate to identify the actual sources of discomfort and prevent unwarranted surgeries injections and therapies.

PLEASE GIVE A DESCRIPTION OF YOUR PRACTICE.
"The P.A.I.N. Institute was created as a 'virtual clinic without walls'—providing the South Bay communities access to a patient-focused approach to the evaluation, diagnosis, treatment and ultimately the management of chronic pain and/or possible co-existing addiction to pain medications or other drugs. The focus of treatment is to offer holistic, individualized and compassionate care. With 30 years of clinical expertise, I have always tried to first ensure that the most accurate working diagnosis is considered in order to understand and address the underlying pain disorder and focus treatment aggressively against the identified 'pain generators.' As an expert in the field of addiction medicine, I always assess the patient's existing dependence on doctor-prescribed medications and maximize the patient's therapeutic options so they may improve physically, psychologically, emotionally and spiritually. There is no place in the world today addressing these issues as an outpatient approach whereby the pain patient is not labeled 'an addict.'"

WHAT WOULD YOU LIKE POTENTIAL PATIENTS TO KNOW ABOUT YOU?
"There isn't a week that goes by that I don't see a patient who underwent an unneeded surgery or procedure. Despite the fact that more than 50% of American families have to deal with pain and/or addiction, there are few pain specialists who understand the treatment of chronic pain beyond the focus of invasive procedures like epidural and facet joint injections. I understand the broad array of painful conditions and diseases that cause chronic pain & addiction disorders. Often mis-diagnosed or, inadequately treated, individuals who suffer from a disease process that results in severe intractable chronic pain, or causes the development of an addictive disorder or, as occurs with doctor prescribed pain medications results in both disorders, may cause a marked deterioration of the individual's way of life. Treating the whole person and not just the disease is where the creativity of the clinical art of medicine combines with the clinical science of medicine in the ultimate pursuit of reducing pain & suffering and, attaining the best quality of life possible!"

WHAT DOES THE FUTURE HOLD FOR YOUR PRACTICE?
"Currently at The P.A.I.N. Institute we are using cutting-edge genetic analysis of patients prior to the use of opiate pain medications in order to identify patients who may have a predisposition to the issue of addiction. The P.A.I.N. Institute is changing the approach to this complex set of problems, instituting a new and innovative pattern of care. After a thorough evaluation, the individual who suffers with a chronic pain or addiction disorder will be educated as to all of the options available to treatment of their condition. Often patients have been told that surgery is necessary when, in reality, the majority of chronic pain conditions do not really need to be treated with surgery. Patients are often surprised at how much they misunderstood what their true choices were."