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STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
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BY [Signature] ANALYST

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:
12 **Eric David Gordon, M.D.**
13 3471 Regional Parkway
Santa Rosa CA 95403
14 Physician's and Surgeon's Certificate
15 No. G82342,
16 Respondent.

Case No. 12-2012-227503

ACCUSATION

17
18 Complainant alleges:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
21 capacity as the Executive Director of the Medical Board of California, Department of Consumer
22 Affairs (Board).

23 2. On or about July 17, 1996, the Medical Board issued Physician's and Surgeon's
24 Certificate Number G82342 to Eric David Gordon, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein
26 and will expire on January 31, 2016, unless renewed.

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

JURISDICTION

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

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

8 6. Section 2234 of the Code, states:

9 “The board shall take action against any licensee who is charged with unprofessional
10 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
11 limited to, the following:

12 “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
13 violation of, or conspiring to violate any provision of this chapter.

14 “(b) Gross negligence.

15 “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
16 omissions. An initial negligent act or omission followed by a separate and distinct departure from
17 the applicable standard of care shall constitute repeated negligent acts.

18 “(1) An initial negligent diagnosis followed by an act or omission medically appropriate
19 for that negligent diagnosis of the patient shall constitute a single negligent act.

20 “(2) When the standard of care requires a change in the diagnosis, act, or omission that
21 constitutes the negligent act described in paragraph (1), including, but not limited to, a
22 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
23 applicable standard of care, each departure constitutes a separate and distinct breach of the
24 standard of care.

25 “(d) Incompetence.

26 “(e) The commission of any act involving dishonesty or corruption which is substantially
27 related to the qualifications, functions, or duties of a physician and surgeon.

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

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

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

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

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

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

15 9. Section 725 of the Code states:

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

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

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1 (c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or
2 administering dangerous drugs or prescription controlled substances shall not be subject to
3 disciplinary action or prosecution under this section.

4 (d) No physician and surgeon shall be subject to disciplinary action pursuant to this section
5 for treating intractable pain in compliance with Section 2241.5."

6 **PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS**

7 10. Abilify, a trade name for aripiprazole, is an anti-psychotic medication that is used to
8 treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic
9 depression). It may also be used together with other medications to treat major depressive
10 disorder in adults. It is a dangerous drug as defined in Business and Professions Code section
11 4022. Taking Abilify with other drugs that induce sleepiness can worsen the effect.

12 11. Actiq. See fentanyl.

13 12. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the
14 imidazopyridine class. It is a Schedule IV controlled substance under Health and Safety Code
15 section 11057(d)(32) and is a dangerous drug as defined in Business and Professions Code section
16 4022. It is indicated for the short-term treatment of insomnia. It is a central nervous system
17 (CNS) depressant and should be used cautiously in combination with other CNS depressants.
18 Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should
19 be administered cautiously to patients exhibiting signs or symptoms of depression because of the
20 risk of suicide. Because of the risk of habituation and dependence, individuals with a history of
21 addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

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

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

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

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

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

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1 17. Hydrocodone bitartrate with acetaminophen, which is known by the trade names
2 Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as
3 defined by section 11055, subdivision (b) of the Health and Safety Code, and is a Schedule II
4 controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal
5 Regulations¹, and is a dangerous drug as defined in Business and Professions Code section 4022.

6 18. Ketamine is a short-acting dissociative injectable anesthetic that has some
7 hallucinogenic effects. It induces a trance-like state while providing pain relief, sedation, and
8 memory loss. It is a Schedule III controlled substance, as defined by section 11056 of the Health
9 and Safety Code and is a dangerous drug as defined in Business and Professions Code section
10 4022. Although primarily used in humans as an anesthetic, it may also be used for post-operative
11 pain management or to treat major depression. In some limited cases it may be used to treat
12 complex regional pain syndrome but its use in treating non-cancer chronic pain is considered to
13 be controversial or experimental. Ketamine may increase the effects of other sedatives, such as
14 alcohol, benzodiazepines, opioids, and barbiturates. It also has a high potential for abuse and for
15 diversion.

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

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

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

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

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

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

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

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

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

16 26. Valium, a trade name for diazepam, is a psychotropic drug used for the management
17 of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV
18 controlled substance as defined by section 11057 of the Health and Safety Code and section
19 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in
20 Business and Professions Code section 4022. Diazepam can produce psychological and physical
21 dependence and it should be prescribed with caution particularly to addiction-prone individuals
22 (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation
23 and dependence.

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

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

4
5 **FIRST CAUSE FOR DISCIPLINE**

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

8 28. Respondent Eric David Gordon, M.D. is subject to disciplinary action under sections
9 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
10 omissions, with regard to patient PJ constitutes gross negligence and/or incompetence and/or
11 prescribing without an appropriate prior examination and a medical indication and/or excessive
12 prescribing, as more fully described herein below.

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

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

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

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

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

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

8 34. On or about October 1, 2010, Respondent issued to patient PJ a prescription for the
9 following controlled substances: #210 MS Contin 200 mg. with instructions for 3-4 tablets to be
10 taken twice daily; #210 Valium 10 mg. with instructions for 3 tablets to be taken twice daily; and
11 #7 Actiq 1600 mcg. lozenges to be taken as needed (prn).

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

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

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

21 38. On or about January 11, 2012, Respondent administered in his office to patient PJ
22 5,000 mcg. of fentanyl intravenously over thirty minutes without any result. Respondent then
23 administered intravenously another 10,000 mcg. of fentanyl over a period of one hour and the
24 patient had some relief.

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

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

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

3 42. Although not adequately documented in the medical records, sometime in March
4 2012, Respondent gave patient PJ bags of fentanyl to take home and to self-administer via the i.v.
5 port. A brief handwritten note dated March 16, 2012 from Respondent appears to instruct patient
6 PJ to use no more than two 15, 000 mcg. bags a day, with each bag to be run over two hours.
7 Respondent did not document in the patient's chart how many bags of i.v. fentanyl were
8 dispensed and the medical indication for this prescribing.

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

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

15 45. A nurse's note dated April 2, 2012 documents that three bags of Ringer's lactate with
16 1500 mcg. each of fentanyl was made up by Respondent and given to patient PJ to take on
17 vacation.

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

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

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

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

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

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

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

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

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

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

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

1 patient would self-administer 60,000 mcg. of i.v. fentanyl on one night a week at home.

2 Respondent, however, did not adequately document in the patient's chart the indication for this
3 change in dosing and when the change was made.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **SECOND CAUSE FOR DISCIPLINE**

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

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

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

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

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

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

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

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

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

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

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

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

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

18 71. According to the CURES report for six-months in 2014 (January 21, 2014 through
19 July 23, 2014), Respondent prescribed and patient DF obtained the following controlled
20 substances: #4,704 fentanyl citrate oral transmucosal lozenges 1600 mcg.; #90 fentanyl
21 transdermal 100 mcg/hr. patches; #1440 morphine sulfate 30 mg. time-extended release tablets;
22 #900 morphine sulfate 15 mg. time-extended release tablets; #1500 methadone hydrochloride 10
23 mg. tablets; #450 diazepam 10 mg. tablets; and, #150 zolpidem tartrate 5 mg. tablets.

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

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

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

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

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

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

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

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

16 g. Respondent's records are inadequate and incomplete and do not include sufficient
17 information to explain medical decisions, documentation of appropriate physical examinations,
18 reports of functional status, accurate lists of current medications and current objective findings.

19 The computer chart entries were often copied from previous visits, making it confusing and
20 impossible to determine what information is current;

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

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

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

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1 **THIRD CAUSE FOR DISCIPLINE**

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

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

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

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

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

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

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

25 79. According to the prescribing records, between October 30, 2009 through at least
26 November 15, 2013, Respondent had prescribed to patient JE up to 800 mg. of methadone per day
27 while at the same time prescribing daily 36 mg. of alprazolam and 720 mg. of oxycodone.
28

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 5 **FOURTH CAUSE FOR DISCIPLINE**

6 **(Unprofessional Conduct: Gross Negligence, Incompetence, Prescribing Without** 7 **Appropriate Exam and Medical Indication, Excessive Prescribing re Patient VT)**

8 90. Respondent Eric David Gordon, M.D. is subject to disciplinary action under sections
9 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
10 omissions, with regard to patient VT constitutes gross negligence and/or incompetence and/or
11 prescribing without an appropriate prior examination and a medical indication and/or excessive
12 prescribing, as more fully described herein below.

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

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

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

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

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

3 96. In or about November 2011, patient VT had a consultation with a specialist about
4 headaches and that physician recommended that the patient limit the use of Norco to no more than
5 10 days a month. Respondent received a copy of the report but did not change his prescribing of
6 Norco to patient VT, which was about #90 tablets monthly.

7 97. According to the CURES report, in 2014 Respondent prescribed the following
8 controlled substances to patient VT: #990 Ambien 10 mg. tablets; #900 tramadol hydrochloride
9 50 mg. tablets; #1440 carisoprodol (Soma) 350 mg. tablets; #1680 Norco 325 mg./10 mg. tablets;
10 an unknown quantity of #37 ketamine hydrochloride powder; and #90 Nuvigil 150 mg.

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

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

- 20 a. Respondent prescribed excessively high doses of Ambien to patient VT without
21 documenting a recognized medical indication;
- 22 b. Respondent did not document informing patient VT of the risks and benefits of
23 the chronic use of opioids along with other treatment modalities;
- 24 c. Respondent made no attempts to monitor the patient's chronic use of prescribed
25 opioids;
- 26 d. Respondent did not obtain and document a substance abuse history for patient VT;
- 27 e. Respondent's records are inadequate and incomplete and do not include sufficient
28 information to explain medical decisions, documentation of appropriate physical examinations,

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

4
5 **FIFTH CAUSE FOR DISCIPLINE**

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

8 100. Respondent is subject to disciplinary action for unprofessional conduct under section
9 2266 for failure to maintain adequate and accurate records relating to the provision of services to
10 patient PJ and/or patient DF and/or patient JE and/or patient VT, as alleged in paragraphs 28
11 through 99, which are incorporated herein by reference as if fully set forth.

12
13 **SIXTH CAUSE FOR DISCIPLINE**

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

15 101. In the alternative, Respondent is subject to disciplinary action for unprofessional
16 conduct, jointly and severally, under section 2234(c) for repeated negligent acts with regard to his
17 acts and/or omissions with regards to patient PJ and/or patient DF and/or patient JE and/or patient
18 VT, as alleged in paragraphs 28 through 99, which are incorporated herein by reference as if fully
19 set forth.

20 **PRAYER**

21 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
22 and that following the hearing, the Medical Board of California issue a decision:

- 23 1. Revoking or suspending Physician's and Surgeon's Certificate Number G82342,
24 issued to Eric David Gordon, M.D.;
- 25 2. Revoking, suspending or denying approval of Eric David Gordon, M.D.'s authority to
26 supervise physician assistants, pursuant to section 3527 of the Code;

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3. Ordering Eric David Gordon, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: October 16, 2015


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

SF2015402390