

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

In the Matter of the First Amended  
Accusation  
Against

John Courtney Dozier, M.D.

Physician's and Surgeon's  
Certificate No. G46031

Respondent.

Case No. 800-2017-033164

DECISION


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

This Decision shall become effective at 5:00 p.m. on

JUN 19 2020.

IT IS SO ORDERED JUN 12 2020.

MEDICAL BOARD OF CALIFORNIA

By:   
Christine J. Lally  
Interim Executive Director

1 XAVIER BECERRA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 RYAN J. YATES  
Deputy Attorney General  
4 State Bar No. 279257  
1300 I Street, Suite 125  
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7

8 *Attorneys for Complainant*

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

14 In the Matter of the First Amended Accusation  
Against:

15 **JOHN COURTNEY DOZIER, M.D.**  
16 **Box 1726**  
**Susanville, CA 96130**

17 **Physician's and Surgeon's Certificate**

18 **No. G 46031**

19 Respondent.

Case No. 800-2017-033164

OAH No. 2019081063

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

20  
21 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical  
25 Board of California (Board). She brought this action solely in her official capacity and is  
26 represented in this matter by Xavier Becerra, Attorney General of the State of California, by Ryan  
27 J. Yates, Deputy Attorney General.

28 \\\



1 **CULPABILITY**

2 10. Respondent understands that the charges and allegations in First Amended  
3 Accusation No. 800-2017-033164, if proven at a hearing, constitute cause for imposing discipline  
4 upon his Physician's and Surgeon's Certificate.

5 11. For the purpose of resolving the First Amended Accusation without the expense and  
6 uncertainty of further proceedings, Respondent agrees that, at a hearing, complainant could  
7 establish a *prima facie* case with respect to the charges and allegations contained in First  
8 Amended Accusation No. 800-2017-033164 and that those charges constitute cause for discipline.  
9 Respondent hereby gives up his right to contest that cause for discipline exists based on those  
10 charges.

11 13. Respondent understands that by signing this stipulation he enables the Board to issue  
12 an order accepting the surrender of his Physician's and Surgeon's Certificate without further  
13 process.

14 **RESERVATION**

15 14. The admissions made by Respondent herein are only for the purposes of this  
16 proceeding, or any other proceedings in which the Medical Board of California or other  
17 professional licensing agency is involved, and shall not be admissible in any other criminal or  
18 civil proceeding.

19 **CONTINGENCY**

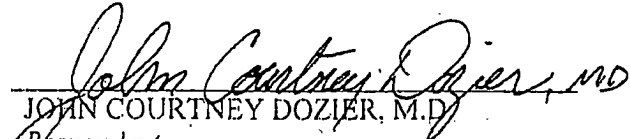
20 15. This stipulation shall be subject to approval by the Board. Respondent understands  
21 and agrees that counsel for Complainant and the staff of the Board may communicate directly  
22 with the Board regarding this stipulation and surrender, without notice to or participation by  
23 Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he  
24 may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board  
25 considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order,  
26 the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this  
27 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not  
28 be disqualified from further action by having considered this matter.




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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney D. Marc Lyde. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: March 24, 2020   
JOHN COURTNEY DOZIER, M.D.  
*Respondent*

I have read and fully discussed with Respondent John Courtney Dozier, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 03-25-20   
D. MARC LYDE  
*Attorney for Respondent*

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

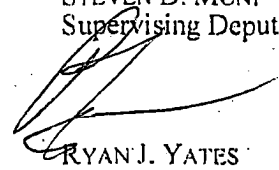
DATED: 5/18/20 Respectfully submitted,  
XAVIER BECERRA  
Attorney General of California  
STEVEN D. MUNI  
Supervising Deputy Attorney General  
  
RYAN J. YATES  
Deputy Attorney General  
*Attorneys for Complainant*

EXHIBIT A

1 XAVIER BECERRA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 RYAN YATES  
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7 *Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO *May 16* 20 *19*  
BY *[Signature]* ANALYST

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

12  
13 In the Matter of the First Amended Accusation  
Against:

Case No. 800-2017-033164

14 John Courtney Dozier, M.D.  
15 P.O. Box 1726  
Susanville, CA 96130

FIRST AMENDED ACCUSATION

16 Physician's and Surgeon's Certificate  
17 No. G 46031,

18 Respondent.

19  
20 Complainant alleges:

21 PARTIES

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

25 2. On or about September 16, 1981, the Medical Board issued Physician's and  
26 Surgeon's Certificate Number G 46031 to John Courtney Dozier, M.D. (Respondent). The  
27 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the  
28 charges brought herein and will expire on May 31, 2019, unless renewed.



1 agreed to with the board and successfully completed by the licensee, or other matters  
2 made confidential or privileged by existing law, is deemed public, and shall be made  
3 available to the public by the board pursuant to Section 803.1.”

4 6. Section 2234 of the Code, states:

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

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

10 “(b) Gross negligence.

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

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

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

23 “(d) Incompetence.

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

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

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

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

9           7. Section 2241 of the Code states:

10           “(a) A physician and surgeon may prescribe, dispense, or administer  
11 prescription drugs, including prescription controlled substances, to an addict under his  
12 or her treatment for a purpose other than maintenance on, or detoxification from,  
13 prescription drugs or controlled substances.

14           “(b) A physician and surgeon may prescribe, dispense, or administer  
15 prescription drugs or prescription controlled substances to an addict for purposes of  
16 maintenance on, or detoxification from, prescription drugs or controlled substances  
17 only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218,  
18 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall  
19 authorize a physician and surgeon to prescribe, dispense, or administer dangerous  
20 drugs or controlled substances to a person he or she knows or reasonably believes is  
21 using or will use the drugs or substances for a nonmedical purpose.

22           “(c) Notwithstanding subdivision (a), prescription drugs or controlled  
23 substances may also be administered or applied by a physician and surgeon, or by a  
24 registered nurse acting under his or her instruction and supervision, under the  
25 following circumstances:

26           “(1) Emergency treatment of a patient whose addiction is complicated by the  
27 presence of incurable disease, acute accident, illness, or injury, or the infirmities  
28 attendant upon age.

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“(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

“(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

“(d)(1) For purposes of this section and Section 2241.5, “addict” means a person whose actions are characterized by craving in combination with one or more of the following:

“(A) Impaired control over drug use.

“(B) Compulsive use.

“(C) Continued use despite harm.

“(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.”

8. Section 2242 of the Code states:

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

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

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

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



1 oxycodone intoxication. Morbid obesity and hypertensive and atherosclerotic cardiovascular  
2 disease were other significant conditions.

3 12. Patient A was a 54-year-old female at the time that she started treating with  
4 Respondent. At that initial visit she was diagnosed as having hypertension, hypothyroidism,  
5 diabetes mellitus type II, depression, morbid obesity and severe degenerative joint disease of the  
6 knees. She was taking multiple medications including Metformin<sup>3</sup>, Synthroid<sup>4</sup>, Cozaar<sup>5</sup>,  
7 Atenolol<sup>6</sup>, hydrochlorothiazide<sup>7</sup>, Halcion<sup>8</sup>, Paxil<sup>9</sup>, Celebrex<sup>10</sup>, alprazolam<sup>11</sup> 1 mg per day and  
8 Norco<sup>12</sup> 10 mg 5 per day. Patient A was also on methadone<sup>13</sup> which was not noted on the initial  
9 visit of February 16, 2006<sup>14</sup>, but later was noted on her second visit of March 22, 2006. At that  
10 second visit it was noted that Patient A was on "methadone tapering off".

11 13. On December 8, 2008, Respondent noted in Patient A's medical record that she had  
12 completed a "rehabilitation program for prescription drug addiction." Respondent also noted,

13 <sup>3</sup> Metformin is used to treat high blood sugar levels that are caused by a type of diabetes  
14 mellitus or sugar diabetes called type 2 diabetes.

15 <sup>4</sup> Synthroid (levothyroxine) treats hypothyroidism (low thyroid hormone) and different  
16 types of goiters (enlarged thyroid gland).

17 <sup>5</sup> Cozaar (losartan) is used to treat high blood pressure (hypertension) and to help protect  
18 the kidneys from damage due to diabetes

19 <sup>6</sup> Atenolol, is a medication of the beta blockers type, primarily used to treat high blood  
20 pressure and angina.

21 <sup>7</sup> Hydrochlorothiazide is used to treat fluid retention (edema) that is caused by congestive  
22 heart failure, severe liver disease (cirrhosis), kidney disease, or treatment with a steroid or  
23 hormone medicine.

24 <sup>8</sup> Halcion is a fast-acting benzodiazepine commonly prescribed for acute insomnia.

25 <sup>9</sup> Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective  
26 serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be  
27 unbalanced in people with depression, anxiety, or other disorders

28 <sup>10</sup> Celebrex is a nonsteroidal anti-inflammatory drug used to treat pain or inflammation.

<sup>11</sup> Alprazolam is a benzodiazepine. Alprazolam affects chemicals in the brain that may be  
unbalanced in people with anxiety. Alprazolam is used to treat anxiety disorders, panic disorders,  
and anxiety caused by depression. Alprazolam is a Schedule IV controlled substance pursuant to  
Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

<sup>12</sup> Norco (acetaminophen and hydrocodone) is used to relieve moderate to severe pain.  
Norco (hydrocodone) is a Schedule II controlled substance pursuant to Health and Safety Code  
section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code  
section 4022.

<sup>13</sup> Methadone is a Schedule II controlled substance pursuant to Health and Safety Code  
section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code  
section 4022.

<sup>14</sup> Conduct occurring more than seven (7) years from the filing date of this Accusation is  
for informational purposes only and is not alleged as a basis for disciplinary action.

1 Patient A was seeing a psychiatrist, Dr. B. in Reno and a counselor Dr. R. in Susanville. At that  
2 point the Patient A was only taking Tylenol for pain. Respondent did not list substance abuse as a  
3 problem in his problem list.

4 14. On January 12, 2010, Patient A was "worked in early" for "increasing pain with cold,  
5 damp weather". Patient A had been using ibuprofen with inadequate pain control. The medical  
6 note states "she has had trouble in the past with minor tranquilizers in combination with opiates  
7 but she states that her problems were actually more with the minor tranquilizers." The medical  
8 note stated Patient A did tolerate Oxycodone reasonably well in the past. The medical note stated  
9 Patient A's pain was in the shoulders, low back, hands and the big toes. It also stated, Patient A's  
10 "knees are doing relatively well but she has had bilateral knee replacements." Respondent's  
11 treatment plan indicated that he would start her back on opiates and "monitor her closely".  
12 Respondent reminded Patient A that "since she had only a single kidney that she should avoid  
13 nonsteroidal anti-inflammatory drugs as much as possible." Respondent gave her Tramadol 50  
14 mg every 4 hours as needed for pain. Respondent also gave her Oxycodone 5/325 one every 6  
15 hours as needed for pain not controlled by the Tramadol<sup>15</sup>. Respondent indicated he would be  
16 checking laboratory studies.

17 15. On February 17, 2010, Respondent discontinued Patient A's Tramadol and placed her  
18 on Oxycodone 5mg, two in the morning and two at night. No laboratory results were documented.

19 16. On March 19, 2010, no labs were documented and there was no discussion of the  
20 opiate treatment in Respondent's medical note.

21 17. On September 21, 2010, no labs were documented but Respondent performed a back  
22 examination, Patient A was started on Alprazolam once again without mention of the prior  
23 problems she had with Alprazolam abuse previously noted in 2008 in Respondent's records. The  
24 oxycodone was increased to 5 mg 1 or 2 every 6 hours.

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27 <sup>15</sup> Tramadol is a narcotic-like pain reliever. Tramadol is used to treat moderate to severe  
28 pain.

1 18. On February 1, 2011, the patient was seen but there was no back or knee examination.  
2 Patient A was given a prescription for 30 day's worth of alprazolam and OxyContin<sup>16</sup>.  
3 Respondent also gave Patient A 90 days of the same medications via mail order pharmacy. She  
4 was to return for re-evaluation in four months.

5 19. June 7, 2011, Respondent noted Patient A's pain was "controlled". There was no back  
6 examination and no mention of the continuation of the pain medications. Respondent increased  
7 Patient A's prescription for Alprazolam due to stress from a number of "family issues" mainly  
8 related to her son.

9 20. On July 7, 2011, Respondent saw Patient A for follow up of spine pain and chronic  
10 pain syndrome. Patient A was taking Oxycontin 5 milligrams to be ID. The Alprazolam was  
11 decreased to 0.5 mg q6h.

12 21. On September 15, 2011, Respondent saw Patient A in follow-up for hospitalization  
13 for dehydration and acute renal failure. Respondent indicated in his medical note that the review  
14 of systems was positive for "back pain and joint pain". The musculoskeletal examination was  
15 normal without pain. Patient A's psychiatric examination demonstrated appropriate mood and  
16 affect. Respondent made a comment regarding the "history of chronic pain due to multiple  
17 musculoskeletal problems". In Respondent's treatment plan he did not mention the chronic pain  
18 issues or musculoskeletal condition. For the anxiety state Respondent indicated the patient was  
19 slightly worse and that he would "change directions for one month." Respondent encouraged  
20 restarting of counseling. Alprazolam and Oxycodone continued to be listed on the medication list.

21 22. November 9, 2011, Respondent treated Patient A for chronic conditions including  
22 chronic pain. Respondent noted Patient A was reported to be functional on present analgesic  
23 regimen without adverse effects or non-compliance or diversion. Respondent indicated he would  
24 no longer give 30-day bridging prescriptions. Medications were listed multiple times (Alprazolam  
25 X3 oxycodone X4). Respondent indicated Patient A was being weaned off of opiates by the  
26 psychiatrist. Respondent indicated that Patient A's daughter was managing her regimen.

27 <sup>16</sup> Oxycodone, brand name OxyContin, is a Schedule II controlled substance pursuant to  
28 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

1           23. On March 27, 2012, Respondent saw Patient A for follow up of chronic conditions.  
2 Respondent noted that Patient A was being weaned off her benzodiazepines and she was being  
3 followed by Dr. B. in Reno, and she admitted to overuse of benzodiazepines, which led to a  
4 family intervention four weeks before. Respondent also noted that Patient A was being weaned  
5 off her oxycodone by her psychiatrist and she admits to overuse of prescription opiates.

6           24. On June 17, 2012, Patient A died. The coroner's report findings stated that the death  
7 of Patient A was due to oxycodone intoxication. Morbid obesity and hypertensive and  
8 atherosclerotic cardiovascular disease were other significant conditions.

9           25. Respondent committed gross negligence in his care and treatment of Patient A, which  
10 included, but are not limited to, the following:

11           (a) Respondent departed from the standard of care by failing to coordinate Patient  
12 A's care with the psychiatrist or a pain specialist; and,

13           (b) Respondent departed from the standard of care by failing to closely monitor  
14 Patient A with a known history of substance abuse with Alprazolam and oxycodone; and

15           (c) Respondent departed from the standard of care by failing to keep organized  
16 accurate and legible medical records and his lacking of reference to his own medical records; and

17           (d) Respondent departed from the standard of care by trusting Patient A with 960.5  
18 mg oxycodone in one month due to her known history of substance abuse; and

19           (e) Respondent departed from the standard of care by restarting the prescription of  
20 Patient A's alprazolam without consulting a psychiatrist or reviewing the prior medical records  
21 regarding the prior overuse of alprazolam.

22           26. On or around September 7, 2017, the MBC received an anonymous complaint against  
23 Respondent. The complaint alleged Respondent prescribed controlled medications to patients who  
24 were not taking them. It was also alleged that when a patient's urine drug screen showed that the  
25 patient had not taken the prescribed medication, Respondent continued to prescribe medications  
26 to that patient. CURES reports were obtained on Respondent's prescribing. In Respondent's care  
27 and treatment of patients B, C, and D departures from the standard of care were identified as  
28 follows:

1           Patient B

2           27. Patient B saw Respondent for the first time on April 5, 2012. Patient B was seen for  
3 follow up with chronic problems which included tobacco use disorder, long term use of  
4 anticoagulants, other aneurysm of unspecified site, peripheral vascular disease, chronic pain  
5 syndrome, gastroesophageal reflux and insomnia. Respondent did not perform a complete history  
6 and physical. Patient B's assessment for the chronic pain syndrome was from prior right femur  
7 fracture with open reduction and internal fixation (ORIF)<sup>17</sup> with intra-medullary rod years ago.  
8 Patient B presented at the visit with a chronically draining open wound on the right hip also  
9 chronic chest wall pain from prior sternotomy for vascular procedures. Respondent's medical  
10 records indicated there was fair control with MS Contin and oxycodone. The specific exact  
11 dosages were not listed. Respondent conducted an examination of patient B's chest which showed  
12 multiple surgical scars over the anterior chest wall and the midline sternotomy scar. A  
13 musculoskeletal examination showed a deep open wound at the lateral aspect of right hip with no  
14 significant drainage, surrounding erythema, or induration. Respondent's conclusion was patient B  
15 suffered from chronic pain which was multifactorial that left patient B disabled for most physical  
16 work. Respondent noted patient B was to continue with the present analgesic regimen and follow  
17 up in six weeks. Respondent also prescribed Neurontin<sup>18</sup> and Protonix<sup>19</sup>. Patient B was followed  
18 every two to four months with minimal physical examinations of his hips or chest.

19           28. On March 20, 2013 patient B was on morphine sulfate 400 mg per day and  
20 oxycodone 240 mg per day. Patient B was reportedly functional on the analgesic regimen without  
21 adverse effects or evidence of non-compliance or diversion.

22           29. On October 16, 2013, patient B was seen by the Respondent for chronic conditions  
23 including peripheral vascular disease, chronic pain syndrome and right hip pain. Patient B  
24 indicated that his medications had been stolen when he was assaulted. Although patient B

25 \_\_\_\_\_  
26 <sup>17</sup> ORIF is the abbreviation for a procedure called open reduction internal fixation which  
is meant to repair compound bone fractures or severe breaks.

27 <sup>18</sup> Neurontin is a medication used to help manage certain epileptic seizures and relieve  
pain for some conditions, such as shingles.

28 <sup>19</sup> Protonix (pantoprazole sodium) is a proton pump inhibitor (PPI) used to treat  
gastroesophageal reflux disease and a history of erosive esophagitis.

1 complained of back pain, Respondent did not conduct a back examination. Respondent's medical  
2 record stated that patient B's chronic pain syndrome was worse due to his vascular compromise  
3 and the MS Contin was increased to 130 mg four times a day. Patient B was told to stop using  
4 methamphetamine. Respondent did not make any changes to the opiates patient B was prescribed.

5 30. On February 12, 2014, patient B was seen by the Respondent for chronic conditions  
6 and for anxiety. Respondent did not perform a physical examination. Patient B still had chronic  
7 chest pain and right hip pain. Patient B reported that he had increased anxiety due to the decrease  
8 in the pain medication. Respondent prescribed Diazepam for patient B's chest pain and shortness  
9 of breath causing anxiety.

10 31. On October 9, 2014, patient B was seen by the Respondent and was going to slowly  
11 taper his oxycodone down to six or seven per day as tolerated. Patient B's morphine intake was to  
12 be reduced to 160 mg twice a day. There was no further reduction in patient B's medication until  
13 April 17, 2015, when patient B was on 590 morphine milligram equivalents per day. Respondent  
14 performed a minimal physical examination. Respondent noted patient B had tenderness in his  
15 lower back. Respondent's plan was to decrease patient B's use of opioids by ten percent.

16 32. On August 7, 2015, patient B was seen by the Respondent with a notation that his  
17 medication had been reduced from 560 to 530 morphine milligrams equivalents per day.  
18 Respondent did not conduct a back or hip examination. Respondent noted patient B's tapering of  
19 medication was to continue.

20 33. On January 26, 2016, patient B was seen by the Respondent for chronic pain  
21 syndrome. Patient B was seen after a long absence and there was no explanation for the long  
22 absence noted by Respondent. Patient B's drug screen that day showed the presence of  
23 methamphetamine. Patient B stated that his medications had been stolen. Patient B was on 115  
24 mg morphine sulfate extended-release per day plus oxycodone 30 mg 6 per day.

25 34. On March 31, 2016, patient B was seen by the Respondent for follow-up of chronic  
26 pain syndrome with chest pain and right arm pain. Patient B was taking morphine sulfate  
27 extended-release 100 mg twice a day and oxycodone 30 mg six times per day. Patient B's urine  
28 drug screens in February 2016 showed methamphetamine and also opiates that were not

1 prescribed by Respondent. Respondent noted that patient B continued to be non-compliant with  
2 his prescriptions. Respondent did not change Patient B's prescription.

3 35. On June 29, 2017, patient B was seen by the Respondent for a chronic pain syndrome.  
4 Respondent's physical examination showed that when the patient elevated his arms above the  
5 shoulders his hands turned pale and caused more pain after five seconds. Respondent's  
6 musculoskeletal examination showed both hands were warm although the right arm radial and  
7 ulnar pulses could not be felt. Respondent's back examination showed mild tenderness to  
8 palpation over the lower back and upper back. Respondent's assessment was patient B continued  
9 to have significant amount of pain for multiple sites including his arms and hips as well as his  
10 back, and his arm pain might be vascular in etiology. Patient B's hip and spine pain were felt to  
11 be most likely due to multiple traumas over many years. Respondent did not order imaging of  
12 patient B's hips. Respondent reviewed a consultation note from a pain management specialist in  
13 which a tapering program was recommended. Respondent continued Morphine at 45 mg  
14 extended-release twice a day and Oxycodone was to be decreased from 15 mg four times a day to  
15 10 mg 4 times a day. Patient B was to be rechecked again in 3 months. Patient B was to continue  
16 diazepam 5 mg twice a day.

17 36. On July 3, 2017, patient B's urine drug screen again showed a heroin metabolite. The  
18 last opiate prescription from Respondent to patient B was prescribed in September of 2017. There  
19 was no specific chart note addressing the finding of heroin in the drug screens.

20 37. Respondent committed gross negligence in his care and treatment of patient B, which  
21 included, but are not limited to, the following:

22 (a) Paragraphs 26 through 35, above, are hereby incorporated by reference as if  
23 fully set forth herein; and,

24 (b) Respondent departed from the standard of care by failing to document prior  
25 treatment with opiates, failing to contact the patient's prior physician regarding this patient, and  
26 failing to note the red flags in the patient;

27  
28

1 (c) Respondent departed from the standard of care by failing to react to the  
2 methamphetamine use with a change in the treatment plan at least to include urine drug screens  
3 on every visit;

4 (d) Respondent departed from the standard of care by delaying over two years in  
5 obliging the patient to see a pain management specialist; and

6 (e) Respondent departed from the standard of care by failing to examine the  
7 patient's pain generators.

8 Patient C

9 38. Patient C was a 56 year-old female who saw Respondent on October 3, 2013, with  
10 diagnoses of chronic pain syndrome due to previously established degenerative disc disease and  
11 degenerative joint disease of the lumbar spine as well as chronic left knee pain. In Respondent's  
12 medical record there was no documentation of a review of the prior imaging studies to support  
13 these diagnoses. Respondent did not review patient C's prior treatments for the chronic pain other  
14 than opiates. Respondent conducted a physical examination of the lumbar spine and the left knee  
15 but no range of motion was recorded for either of those body parts. Patient C also had hepatitis C,  
16 hormone replacement therapy, hyperlipidemia, dermatitis and cardiac arrhythmia. Patient C was  
17 on high dose opiate therapy approximately 600 MME (morphine milligram equivalents) per day.

18 39. On July 2, 2014, patient C was seen by the Respondent. In the medical records  
19 Respondent indicated that based on patient C's pain questionnaire, patient history, review of  
20 systems and physical examination the patient was functional on the present analgesic regimen  
21 without adverse effects. Respondent reviewed patient C's CURES report. Respondent indicated  
22 that patient C would undergo regular monitoring to evaluate the success of these interventions  
23 and to avoid adverse outcomes. Respondent also mentioned that attempts would be made to  
24 reduce medication when appropriate. There was no mention of periodic drug screening in patient  
25 C's medical record.

26 40. By August 3, 2014, patient C's medication was at 1870 MME.

27 41. On May 8, 2017, Respondent initiated a drug screening on patient C.

28 42. Eventually by February 12, 2018, patient C's medication was decreased to 645 MME.

1           43. Respondent committed gross negligence in his care and treatment of patient C, which  
2 included, but are not limited to, the following:

3           (a) Paragraphs 38 through 42, above, are hereby incorporated by reference as if  
4 fully set forth herein; and,

5           (a) Respondent departed from the standard of care by failing to consult with an  
6 orthopedic specialist or pain management specialist regarding the patient's spinal pain and left  
7 knee pain requiring high doses of opiates.

8           Patient D

9           44. Patient D initially saw Respondent on October 20, 2013, with a diagnosis of low  
10 back pain from a prior failed back surgery. Patient D was a patient with high opiate therapy due to  
11 the back pain. Patient D also had significant chronic obstructive pulmonary disease (COPD).  
12 Patient D had peripheral artery disease, atherosclerosis cardiovascular disease and a history of  
13 radiation exposure. Respondent's plan was to continue high-dose opiate therapy and to recheck in  
14 two months to review and discuss his opiate therapy contract at that time. In Respondent's  
15 medical records there was no discussion of patient D's COPD and respiratory compromise which  
16 could be worsened by high-dose opiate therapy. Patient D's prior treatment with opiates was not  
17 clearly specified. In Respondent's medical records there was no discussion of the previous  
18 imaging studies performed on patient D. Respondent did not obtain a pulmonary consultation at  
19 the onset of patient D's treatment with high dose opiates. Respondent did not obtain a pain  
20 management or orthopedic consultation for patient D.

21           45. By April 1, 2014, patient D was taking 2670 MME per day.

22           46. By April 24, 2018, patient D was taking 547.5 MME per day.

23           47. Respondent committed gross negligence in his care and treatment of patient D, which  
24 included, but are not limited to, the following:

25           (a) Paragraphs 44 through 46, above, are hereby incorporated by reference as if  
26 fully set forth herein; and,  
27  
28

1 (b) Respondent departed from the standard of care by failing to initiate opiate  
2 reduction in a more timely fashion and also following this patient with high dosages of opiates at  
3 four months intervals; and

4 (c) Respondent departed from the standard of care by failing to obtain a pain  
5 management, orthopedic, or pulmonary medicine consultation for the patient.

6 48. Respondent's conduct, as described above, constitutes gross negligence in the  
7 practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to  
8 discipline Respondent's license.

9 **SECOND CAUSE FOR DISCIPLINE**

10 **(Repeated Acts of Negligence)**

11 49. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined  
12 by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his  
13 care and treatment of Patients A, B, C, and D.

14 **Patient A**

15 50 Paragraphs 11 through 25, as more particularly alleged above, are hereby  
16 incorporated by reference and realleged as if fully set forth herein.

17 51. Respondent committed acts of repeated negligence in his care and treatment of patient  
18 A, which includes, but are not limited to, the following:

19 (a) Respondent departed from the standard of care by failing to conduct a complete  
20 initial medical history and physical; and

21 (b) Respondent departed from the standard of care by failing to discuss the risks  
22 and benefits of treatment of pain with opiates as demonstrated by the lack of documentation of  
23 informed consent; and

24 (c) Respondent departed from the standard of care by poorly monitoring and record  
25 keeping to account for the actual amounts of Alprazolam the patient was taking.

26 **Patient B**

27 52. Paragraphs 27 through 37, as more particularly alleged above, are hereby  
28 incorporated by reference and realleged as if fully set forth herein.

1           53. Respondent committed acts of repeated negligence in his care and treatment of patient  
2 B, which included, but are not limited to, the following:

3           (a) Respondent departed from the standard of care by failing to consider other  
4 treatments such as physical therapy or stress reduction to treat this patient's chronic pain.

5           Patient C

6           54. Paragraphs 38 through 43, as more particularly alleged above, are hereby  
7 incorporated by reference and realleged as if fully set forth herein.

8           55. Respondent committed acts of repeated negligence in his care and treatment of patient  
9 C, which included, but are not limited to, the following:

10           (a) Respondent departed from the standard of care by failing to document prior  
11 treatments and prior imaging studies in the patient;

12           (b) Respondent departed from the standard of care by failing to perform an  
13 adequate physical examination of patient C's lumbar spine and left knee;

14           (c) Respondent departed from the standard of care by failing to initiate drug  
15 screening on the patient until May 8, 2017; and

16           (d) Respondent departed from the standard of care by failing to document a more  
17 complete examination of the patient's back and left knee.

18           Patient D

19           56. Paragraphs 44 through 47, as more particularly alleged above, are hereby  
20 incorporated by reference and realleged as if fully set forth herein.

21           57. Respondent committed acts of repeated negligence in his care and treatment of patient  
22 D, which included, but are not limited to, the following:

23           (a) Respondent departed from the standard of care by failing to document the prior  
24 treatments and prior imaging studies from the patient.

25           58. Respondent's conduct, as described above, constitutes repeated acts of negligence in  
26 the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to  
27 discipline Respondent's license.

28           ///

1 THIRD CAUSE FOR DISCIPLINE

2 (Excessive Prescribing)

3 59. Respondent is subject to disciplinary action under section 725 of the Code, in that  
4 respondent excessively overprescribed in his care and treatment of patients B, C and D as more  
5 particularly alleged in paragraphs 28 through 48 above, which are hereby incorporated by  
6 reference and realleged as if fully set forth herein.

7 FOURTH CAUSE FOR DISCIPLINE

8 (Furnishing Drugs to an Addict)

9 60. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined  
10 by section 2241, of the Code, in that respondent prescribed controlled substances and dangerous  
11 drugs to patient A, whom he knew or reasonably should have known was using or would be using  
12 the controlled substances and dangerous drugs for a nonmedical purpose, as more particularly  
13 alleged in paragraphs 11 through 24 above, which are hereby incorporated by reference and  
14 realleged as if fully set forth herein.

15 FIFTH CAUSE FOR DISCIPLINE

16 (Prescribing Controlled Substances Without Prior Appropriate Examination)

17 61. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined  
18 by section 2242, of the Code, in that respondent prescribed controlled substances without an  
19 appropriate prior examination and a medical indication in his care and treatment of patient A, as  
20 more particularly alleged in paragraphs 11 through 24 above, which are hereby incorporated by  
21 reference and realleged as if fully set forth herein.

22 SIXTH CAUSE FOR DISCIPLINE

23 (Failure to Maintain Complete and Accurate Medical Records)

24 62. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined  
25 by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records  
26 regarding his care and treatment of patient A, as more particularly alleged in paragraphs 11  
27 through 24 above, which are hereby incorporated by reference and realleged as if fully set forth  
28 herein.

1 PRAYER

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

4 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 46031,  
5 issued to John Courtney Dozier, M.D.;

6 2. Revoking, suspending or denying approval of John Courtney Dozier, M.D.'s  
7 authority to supervise physician assistants and advanced practice nurses;

8 3. Ordering John Courtney Dozier, M.D., if placed on probation, to pay the Board the  
9 costs of probation monitoring; and

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

11  
12 DATED: May 16, 2009

13   
14 KIMBERLY KIRCHMEYER  
15 Executive Director  
16 Medical Board of California  
17 Department of Consumer Affairs  
18 State of California  
19 Complainant

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