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

In the Matter of the Accusation Against:  

GARY RONALD JOHNSON, M.D.  
P.O. Box 580  
San Andreas, CA 95249  

Physician's and Surgeon's Certificate No. G27755  

Respondent.

Complainant alleges:

PARTIES  

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

2. On or about August 12, 1974, the Medical Board of California issued Physician's and Surgeon's Certificate Number G27755 to Gary Ronald Johnson, M.D. (Respondent). In a disciplinary action entitled, "In the Matter of the First Amended Accusation Against: Gary R. Johnson, M.D.," Case number 02-2007-182803, the Medical Board issued a Decision, effective January 30, 2008, in which Respondent's Physician's and Surgeon's Certificate was revoked, but
the revocation was stayed with probation for five (5) years. A copy of that decision is attached as Exhibit A and is incorporated by reference.

3. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2016, unless renewed.

JURISDICTION

4. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

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

6. Section 2234 of the Code states:

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

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

(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2241 of the Code states:

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

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

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:
"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(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 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

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"(3) Violates Section 2242 regarding performing an appropriate prior examination and the
existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances
listed in the California Uniform Controlled Substances Act (Division 10 (commencing with
Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal
Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or
pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A
physician and surgeon shall keep records of his or her purchases and disposals of these controlled
substances or dangerous drugs, including the date of purchase, the date and records of the sale or
disposal of the drugs by the physician and surgeon, the name and address of the person receiving
the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall
otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California
Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of
Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of
Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a
particular patient or condition, or the complexity of a patient's treatment, including, but not
limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a
more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking
disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and
809.5."

9. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

10. Section 725 of the Code states:

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

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

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

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

DRUGS

11. Alprazolam is commonly known by its trade name Xanax. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is in the benzodiazepine family of drugs. It is a dangerous drug as defined in section 4022 of the Business and Professions Code, a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d)(1), of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14, subdivision (c)(2), of Title 21 of the Code of Federal Regulations.

12. Divalproex sodium is commonly known by its trade name Depakote. Depakote is used for the management of certain types of seizures, some psychiatric disorders, and treatment of migraine headaches. Depakote is a dangerous drug as defined in section 4022 of the Business and Professions Code.

13. Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 of the Business and Professions Code, a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(14), of the Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12, subdivision (c)(15), of Title 21 of the Code of Federal Regulations.
14. Metoprolol succinate is commonly known by its trade names Toprol and Lopressor. Toprol is used for the management of high blood pressure. It is a dangerous drug as defined in section 4022 of the Business and Professions Code.

15. Norco, a trade name for hydrocodone/acetaminophen, is used to treat moderate to severe pain. It is a Schedule III controlled substance, as defined by Health and Safety Code section 11056, subdivision (c)(4), and is a dangerous drug pursuant to Business and Professions Code section 4022.

16. Ambien, the trade name for zolpidem, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32), and is a dangerous drug pursuant to Business and Professions Code section 4022.

17. Fluoxetine HCL (Prozac) is a selective serotonin reuptake inhibitor and is categorized as a dangerous drug pursuant to section 4022 of the Code. It is used to treat depression.

18. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Carisoprodol, the generic name for Soma, is a dangerous drug pursuant to Business and Professions Code section 4022.

20. Valium, a trade name for diazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(9), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

21. Duragesic patch is a trade name for a fentanyl transdermal system. Fentanyl is an opioid analgesic whose primary effects are anesthesia and sedation. Duragesic is a Schedule II controlled substance as defined by section 11055, subdivision (c)(8), of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

22. Lexapro is a trade name for escitalopram oxalate. It is a dangerous drug as defined in section 4022 of the Code and is indicated for the acute and maintenance treatment of major depressive disorder and for the treatment of generalized anxiety disorder. Lexapro is a drug with primary CNS effects, and therefore, caution should be exercised with the concomitant use of
sedative hypnotics, narcotic analgesics or other CNS-acting drugs.

23. Trazodone is a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat depression and anxiety disorders (e.g., sleeplessness, tension) and chronic pain.

24. Oxycontin is the brand name for oxycodone, a Schedule II controlled substance under the California Health and Safety Code, section 11055, subdivision (b)(1)(N). Oxycodone is a dangerous drug per Business and Professions Code section 4022 and is indicated for severe pain.

25. Elavil (amitriptyline) is a dangerous drug as defined in section 4022. It is an antidepressant with sedative effects. The usual maintenance dose of amitriptyline HCl is 50 to 100 mg. per day.

26. Gabapentin (Neurontin) is a dangerous drug as defined in Business and Professions Code section 4022 and is an anti-epileptic/anti-convulsant medication. It is also used in the treatment of nerve pain caused by the herpes virus or shingles. Among its known possible side effects are: confusion, dizziness, drowsiness, weakness, tired feeling, lack of coordination, and sleep problems.

27. Naprosyn is a brand name for naproxen sodium, and a dangerous drug pursuant to Business and Professions Code section 4022.

28. AcipHex is a brand name for rabeprazole, an anti-ulcer drug and a dangerous drug pursuant to Business and Professions Code section 4022.

29. Vicodin is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug per Business and Professions Code section 4022. Vicodin is a brand name for the generic drug hydrocodone. It is also known as dihydrocodeinone with the non-narcotic substance acetaminophen and is used to treat pain.

30. Effexor is a brand name for venlafaxine, and a dangerous drug pursuant to Business and Professions Code section 4022. It is an antidepressant in a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSRIs). Effexor affects chemicals in the brain that may become unbalanced and cause depression. It is used to treat major depressive disorder, anxiety, and panic disorder.
31. Zoloft, a trade name for sertraline hydrochloride, is a selective serotonin reuptake inhibitor (SSRI) chemically unrelated to other SSRIs, tricyclic, tetracyclic, or other available antidepressant agents. It is a dangerous drug as defined by section 4022 of the Business and Professions Code. Zoloft is used for the treatment of depression, obsessive compulsive disorder, and panic disorder. Zoloft causes decreased clearance of diazepam (Valium). It has side effects including nausea, diarrhea, dyspepsia, tremor, dizziness, insomnia and somnolence.

32. Paxil, a trade name for paroxetine, is a dangerous drug within the meaning of Business and Professions Code section 4022, and is an oral drug that is used for treating depression. It is in a class of drugs called selective serotonin reuptake inhibitors (SSRIs), a class that also contains fluoxetine (Prozac), citalopram (Celexa), and sertraline (Zoloft).

33. Cymbalta, a trade name for duloxetine, is a dangerous drug within the meaning of Business and Professions Code section 4022. It is a selective serotonin and norepinephrine reuptake inhibitor (SSRI) used for treating depression, anxiety disorder, and pain associated with diabetic peripheral neuropathy or fibromyalgia.

34. Methamphetamine is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (d)(2), and a dangerous drug as designated by Business and Professions Code section 4022. It is a stimulant drug approved by the FDA for treating attention-deficit hyperactivity disorder (ADHD).

35. Dilantin is a brand name for phenytoin sodium and a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the treatment of seizures.

**FIRST CAUSE FOR DISCIPLINE**

*(Gross Negligence)*

*[Bus. & Prof. Code, § 2234, subd. (b)]*

36. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of three patients. The circumstances are as follows:

37. The standard of care requires that a physician who is prescribing controlled substances to treat a patient with pain see the patient periodically in order to monitor the therapy. Appropriate monitoring entails assessing the patient’s progress toward treatment objectives,
assessing the patient’s adherence to treatment with controlled substances, and assessing whether
the patient is having any adverse effects from the controlled substances. This periodic review
enables the physician to determine whether treatment of the patient’s symptoms with controlled
substances should be continued or modified.

38. The standard of care requires that a physician take a history and perform a physical
examination commensurate with the circumstances of the patient’s visit and to the extent
warranted by the patient’s presenting complaint. Should a physician prescribe a controlled
substance to a patient with pain, the standard of care requires that the physician assess the nature
and extent of the pain, the impact of pain upon the patient’s functioning, and inquire about
previous pain treatment and any history of substance abuse. The physician must establish a
legitimate medical indication for the use of a controlled substance.

39. The standard of care requires that a physician have a treatment plan with specific
treatment objectives.

40. When a physician prescribes a patient a controlled substance, the standard of care
requires that the physician discuss with the patient common potential risks and benefits relative to
the use of that substance in order for the patient to make an informed decision to use the
controlled substance.

Patient V.D.C.

41. On or about February 25, 2010, Patient V.D.C. presented to Respondent to establish
treatment with a new primary-care physician. Respondent noted she had chronic low back pain
complicated by anxiety and depression. Respondent also noted she was taking hydrocodone daily
in the management of her pain as well as a mood medicine, citalopram. Patient V.D.C. also had
hypothyroidism and hepatitis C infection. There is no substance use history with the initial visit
apart from the health history questionnaire in which the patient noted smoking 10 to 12 cigarettes
daily.
42. Patient V.D.C.’s having hepatitis C, which is most commonly contracted due to use of illegal drugs and sharing of needles, along with her history of depression, are factors that increase her risk of abusing controlled substances.

43. There was no physical examination with the initial visit. There was no discussion of diagnostic testing to evaluate Patient V.D.C.’s pain complaints. There is no pain management agreement in the medical chart.

44. Despite having no treatment plan documented with the initial visit, Respondent prescribed hydrocodone/acetaminophen 7.5/325, # 150 and escitalopram 10 mg., #28 that day.

45. Respondent engaged in an extreme departure from the standard of care in his care and treatment of Patient V.D.C. in that he failed to perform an appropriate prior examination prior to his prescription of opioid pain medicine to her.

Patient G.G.

46. On or about April 18, 2011, Respondent began treating Patient G.G. upon referral from a family friend. In terms of history, Respondent noted the 49-year-old patient complained of constant low back pain and left leg pain and had been taking pain medication for 4 to 5 years, currently morphine. Respondent did not indicate from whom the patient had been getting his pain medicine, nor did he describe the patient’s past efforts at treatment apart from the mention of medication. Respondent described the location of the pain and its intensity in the note but did not document the impact of the patient’s pain upon his functioning. The health history questionnaire suggests Patient G.G. had no history of substance abuse. Respondent mentioned the patient had previously received psychiatric care. Respondent recorded a physical examination at the initial visit using a checkbox format. There was no abnormality in terms of the musculoskeletal or neurological examinations apart from a few unintelligible handwritten words.

47. Respondent had Patient G.G. get laboratory testing on the day of the initial visit. This included a chemistry panel, lipid panel, testosterone, vitamin D and uric acid levels, complete blood count, glycohemoglobin, TSH, PSA, vitamin B12 and folate levels. There is no indication that Respondent recommended spinal imaging or requested records from earlier spinal diagnostic studies. There is no record of a urine drug screen in connection with the initial visit.
48. Respondent’s primary diagnosis of Patient G.G. was lumbar disc disease and chronic back pain with secondary diagnosis of sleep disturbance, depression, and gout. Respondent noted that he was increasing the dose of morphine and prescribing hydrocodone/acetaminophen 10/325 to treat the pain, prescribing Ambien for sleep disturbance, and prescribing fluoxetine for depression. There is no indication that Respondent checked a CURES report before prescribing controlled substances to the patient to check for signs of doctor-shopping. There is no indication Respondent attempted to obtain prior treatment records to confirm the patient’s history and spinal problem and in particular to corroborate the patient was tolerant to opioid medication before he prescribed him the opioids. If the patient was not tolerant, then the amount of opioid medication that Respondent prescribed Patient G.G. that day placed the patient at risk for opioid-induced harms, including drug overdose and death. There is no indication of an informed consent. There is no indication of a pain management contract. There is no indication Respondent considered alternative pain management treatments for the patient.

49. Respondent engaged in extreme departures in his care and treatment of Patient G.G’s pain in that: (1) he failed to perform an appropriate prior examination and (2) failed to establish a medical indication for the prescription of controlled substances to the patient.

50. Patient J.G. had a long history of back pain, headache, depression, and, starting in 2003, a seizure disorder. Respondent began treating Patient J.G. when he was two years old. His back pain started in 2001 as a result of an automobile accident when Patient J.G. was sixteen years old. He used Vicodin and Soma to treat the pain.

51. On or about May 4, 2005, Respondent noted Patient J.G. had a diagnosis of chronic back pain and “chronic narcotic use” related to the pain condition. Starting in 2010, Respondent’s visit notes for the patient are handwritten, and his treatment plan with respect to his prescribing controlled substances to the patient for chronic pain is vague. There is inadequate documentation concerning the patient’s mental state, particularly with regard to his depression and with respect to his use of alcohol.
52. In March 2010, Patient J.G. was hospitalized for two days. In the discharge summary dated March 4, 2010, the treating physician noted the patient “had been on chronic pain management for a long time” and added the following: “Previously, he was seeing Dr. Johnson for many years and the past four years has been with me. He has been complaining of chronic low back pain in spite of generous morphine dose of 60 mg. q.i.d., 30 mg. of immediate release daily, four tablets of Soma daily and 10 mg. of Valium b.i.d. He has been noticed by wife, family members and friends that last weekend he was under the influence of alcohol and his level of agitation cost him some balance position and a mechanical fall. There were questions of whether he is safe taking his Valium and Norco on top of alcohol. He claims that he drank last weekend because of marital discord, but he never will do it again.” The treating physician made diagnoses of chronic low back pain, insomnia, depression, and an episode of alcohol abuse in conjunction with use of pain medicines. During the brief hospitalization, the physician discontinued Patient J.G.’s Soma, Valium, and Duragesic patch. With the input of a pain medicine specialist, Patient J.G. was started on extended release morphine 240 mg. daily in divided doses. He also started the patient on the antidepressants Lexapro and trazodone, and recommended follow-up with pain management, county mental health, and county drug and alcohol services. The discharge summary states that “the plan was to have the wife control the morphine sulfate,” implying concern about Patient J.G.’s ability to regulate his intake of medicines.

53. The record indicates Patient J.G. decided not to pursue the outpatient treatment recommendations but instead to return to treatment with Respondent shortly after the March 2010 hospitalization. The documents pertaining to the hospitalization are not in Respondent’s file, suggesting that Respondent did not obtain the records in order to review them and incorporate the findings and recommendations into his own treatment plan for the patient.

54. On or about April 9, 2010, Patient J.G. signed a consent for chronic opioid therapy. On or about June 25, 2010, he also signed an “opioid agreement” outlining Respondent’s policy concerning the use of opioids in the treatment of chronic pain. These documents illustrate Respondent was attempting to structure the patient’s treatment with controlled substances.
55. From May 13, 2010, to May 13, 2013, in the time span prior to the patient’s death, the CURES report for this patient shows that Respondent prescribed Patient J.G. methadone, hydrocodone, oxycodone/acetaminophen, and several benzodiazepines, including diazepam, lorazepam, and just prior to his death, alprazolam.

56. Patient J.G.’s medical file contains information regarding a May 2010 arrest for driving under the influence of alcohol (DUI). The clinician who treated Patient J.G. in the jail documented in his May 11, 2010, note that he conferred with Respondent about the treatment plan, so Respondent should have been aware of the patient’s problem with substance abuse by that time even if he had not been aware of what prompted the patient’s hospitalization in March 2010.

57. On or about May 17, 2010, Respondent saw Patient J.G. for follow-up, but there was no discussion in the note pertaining to the recent DUI. Respondent noted the patient had used high dosages of OxyContin and morphine but “didn’t understand he was addicted and would have serious withdrawal” so he would like to have a “few extra” each month. Respondent mentions adding amitriptyline, Neurontin, Naprosyn, hydrocodone, and AcipHex without any further discussion of the patient’s substance abuse problem or how it impacted the treatment plan.


59. On or about June 24, 2011, Patient J.G. began filling more prescriptions with Respondent, resuming opioid therapy with a prescription for methadone.

60. There was a gap in treatment for approximately eight months, from September 7, 2010, until the next visit on June 24, 2011. There was no explanation of the treatment hiatus. The notes give no indication of what happened to the patient during this time frame. It is not stated in the notes whether he was treating with another physician and continuing to take his medication.

61. The June 24, 2011, note documents the patient complained of back pain, depression, and severe anxiety. The note implies he was taking extended release morphine for his chronic
low back pain, and Respondent changed him to methadone. The dose of methadone is unclear and seems to be written to indicate the patient could take two or three tablets per dose, which is not how methadone is generally prescribed. There is no documentation as to how Respondent made the dose conversion, as the frequencies for the drugs are illegible. Patent J.G. filled a prescription from Respondent for 270 tablets of methadone 10 mg. on June 24, 2011.

62. At the July 29, 2011, visit, Respondent obtained a drug screen from the patient. The drug screen was positive for methadone, which was anticipated, but also positive for fentanyl and hydrocodone, which were not anticipated. It is not clear why the patient tested positive for fentanyl and hydrocodone, and Respondent did not address the inconsistency. The drug screen suggests the patient was using opioids that Respondent was not prescribing.

63. On or about September 17, 2011, Patient J.G. complained of migraine, left knee pain, depression, anxiety, and family problems. He was taking methadone 60 mg. daily in divided dose and lorazepam 1 mg. with an occasional extra dose “for stress.” Respondent increased the patient’s methadone dose from 60 mg. to 90 mg. daily, which at a 50% increment is a rather large increase in the methadone dose.

64. On or about October 2, 2011, Patient J.G.’s significant other brought him to Mark Twain emergency room with a one week history of vomiting blood. The notes described him as tearful and smelling like alcohol. On or about October 15, 2011, Patient J.G. was treated for a generalized motor seizure with three prior seizures earlier the same month. The clinician noted the patient has started taking Dilantin.

65. On or about December 19, 2011, Patient J.G. made a suicide attempt with Xanax 4 mg.: “Patient stated with slurred speech that he was trying to relax.” He had been under family stress.

66. On or about December 20, 2011, Patient J.G. was admitted to Mark Twain with a diagnosis of “drug overdose as a possible suicide attempt.” The note indicated the patient was a 27-year-old man “with an apparent history of depression and prior suicide attempts. Apparently he had been arguing a lot with his wife recently, became upset, took apparently 4 mg. of Valium and Vicodin and became transiently unconscious.” Upon presentation, the patient was
“stuporous, unable to provide much of a history,” and was admitted for observation. The treating physician noted that Patient J.G. was taking Depakote 250 mg. twice daily, Xanax 1 mg., three times daily, and Lopressor 25 mg. daily. In discussion of past medical history, the physician noted depression and “prior suicide attempts although the nature and the details of these are unclear.” The admission record showed the patient had taken the Xanax with vodka. During the hospitalization, the treating physician talked to a representative from Respondent’s office regarding the patient’s misuse of Xanax. The treating physician recommended discontinuing Xanax and prescribing Lexapro or Paxil. Patient J.G. was then discharged to a mental health facility on an involuntary hold.

67. The evaluation by the mental health provider, S.R., provides additional salient information about the patient’s mental state during this time frame. She noted, “Client attempted to end his life. Client continues to endorse depression and suicidal thoughts (no plan). Client has increased alcohol over past two weeks. Attempt because of a fight with girlfriend. Client would return to the same [volatile] situation which could result in impulsive attempt and girlfriend feels incapable of helping client stay safe.” She interviewed the girlfriend and the father “and both stated they did not feel capable of keeping or helping [client] stay safe.” She noted his family had his firearms, because he had “put a 22 in his mouth a year ago when drinking.” S.R. noted he had been off methadone for two weeks and during that time frame had increased his use of alcohol. She noted that Respondent was “his prescribing doctor” and indicated Respondent’s phone number in the note. She said, “Writer does not feel as if [client] is able to control impulses if he should return to girlfriend’s home, where the conflict has no resolution. [Client] is hostile when attempting a safety plan for his medications, refusing to do so.” She described his affect as tearful, depressed, and hostile, and his appearance as unkempt. She noted he had run from the hospital three times and had to be returned by law enforcement.

68. During the time the above events transpired, Respondent saw Patient J.G. in his office on multiple occasions, including October 3, 2011, October 21, 2011, November 21, 2011, and January 5, 2012. Respondent continued to document that the patient suffered from depression and anxiety. In his November 21, 2011, note, Respondent indicated the patient had tried various
antidepressants, including Effexor, Zoloft, Prozac, Paxil, Cymbalta, and Lexapro, yet there is no indication of a change in treatment plan or consideration of psychiatric consultation. Respondent’s treatment notes do not mention the hospitalization and its impact upon the treatment plan. Following the hospitalization, Respondent had one more visit with Patient J.G. in early January 2012.

69. At his last visit with the patient on January 5, 2012, Respondent documented the patient was “very depressed.” The checkbox on the history form suggests the patient did not have suicidal ideation. There was no indication Respondent considered referring the patient for psychiatric consultation or considered altering the patient’s controlled substances prescriptions to lessen the patient’s risk for misuse of the drugs, potential overdose, and death. Respondent prescribed the patient oxycodone 10 mg. #60, alprazolam 1 mg. #90, and methadone 10 mg. #180. The CURES report indicates the patient filled these prescriptions on January 6, 2012.

70. The patient died of an apparent suicide by overdose on January 11, 2012. In a note dated the next day, Respondent noted the following:

"Patient was initially refused medication refills and father intervened and agreed to pay for the visit and manage son’s medication. Suicide was discussed with patient and father and denied any intent and stated he could easily have done it already if he wanted to. Father also acknowledged patient had guns in his possession. Father also backed up patient’s story that he had not attempted suicide and that wife had stolen meds and lied about him. Patient was intending to stay with his father until he got his own place and move out of residence with his estranged wife."

71. The statements the patient and his father allegedly made to Respondent on January 5, 2010, contradict what they said when the patient was in the hospital in December, as was documented in Patient J.G.’s mental health evaluation. Nonetheless, a reasonably careful physician would have corroborated the nature of the December 2011 hospitalization by obtaining those records and/or speaking to the clinicians involved in the patient’s care during the hospitalization, and then altered the treatment plan so the patient would not be prescribed a potentially lethal amount of medication.
72. Patient J.G. was at high risk for suicide due to chronic depression, concurrent alcohol abuse, prior history of suicide attempts, and acute situational stress in terms of separation from his wife.

73. Respondent engaged in an extreme departure from the standard of care in his care and treatment of Patient J.G. in that he failed to provide proper oversight in order to monitor the patient’s use of controlled substances.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)
[Bus. & Prof. Code, § 2234, subd. (c)]

74. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), for his repeated acts of negligence in his care and treatment of patients. The circumstances are as follows:

75. Paragraphs 37 through 40 are incorporated herein as if fully set forth.

Patient B.M.

76. Patient B.M. is a young woman who sustained injury in a fall in 2009. She was in treatment with another physician and receiving strong opioid analgesics before Respondent first examined her on July 8, 2010. She was thirty years old at the time Respondent began treating her. He continued to follow her for treatment of pain related to her mid and low back pain as well as migraine. Respondent also diagnosed her with depression and anxiety disorders. He thereafter generally saw her monthly.

77. On or about January 7, 2012, records from Dameron Hospital where she was examined indicate a primary diagnosis of infectious mononucleosis with a secondary diagnosis of “drug use.” The date stamp at the top of the fax suggests Respondent received the fax on January 11, 2012. Her urine drug screen at the time was positive for cannabis, methadone, and benzodiazepine. The charting indicated that she “abuses marijuana.” Another test showed positive for cannabis as well as cocaine.

78. On or about February 2, 2011, a urine drug screen at Lodi Memorial Hospital was positive for benzodiazepine, cannabis, cocaine, and opiate. Respondent ordered two of the screens. On or about June 21, 2011, a urine drug screen was positive for fentanyl, which was not
anticipated. On or about July 18, 2011, a urine drug screen was positive for methadone and benzodiazepine and negative for illicit substances, including cannabis and methamphetamine.

79. On or about November 16, 2012, Respondent noted that the patient was “having constant daily headaches” in addition to low back and left shoulder pain. He also cited PTSD and anxiety. “Patient is able to do all of her daily activities and take care of the household and kids. Her migraines generally are minimal and have not been bad.” Respondent recommended continuing adjustments to her medicines, including increasing her dose of Neurontin “and decreasing and eventually eliminating soma and Valium.”

80. On or about December 14, 2012, Respondent noted she was still using oxycodone and methadone “but has been very good and stable with this and has not abused it.” He noted her migraines were lessening in severity. Respondent recommended she exercise, follow-up with a gynecologist, and reminded her to have her laboratory testing done.

81. Respondent was using urine drug testing to monitor Patient B.M.’s adherence to treatment and as such should have documented how the finding of her testing positive for cannabis and cocaine impacted his treating her with controlled substances. Use of these substances by the patient implies an increased risk for prescription drug abuse and diversion. Respondent engaged in a departure from the standard of care by failing to incorporate the urine test results into his treatment plan.

Patient V.D.C.

82. Complainant re-alleges paragraphs 41 through 45, inclusive above, incorporated by reference as if fully set forth herein.

83. Respondent engaged in a departure from the standard of care in his care and treatment of Patient V.D.C. when he failed to perform an appropriate prior examination prior to his prescription of opioid pain medicine to her.

84. Since initiating treatment on or about February 25, 2010, Respondent saw Patient V.D.C. on a regular basis for periodic visits. He prescribed medication monthly through 2012. On or about August 23, 2010, Respondent started prescribing the patient methadone. On or about
February 14, 2012, Respondent noted that he planned to start Neurontin in addition to methadone for “neuropathy” in the right lower limb.

85. In regard to monitoring the patient’s adherence to treatment with the pain medicines, Respondent ordered two urine drug screens in 2011 but did not check a CURES report. There is also no indication that he discussed whether she was having any difficulty controlling her use of the medicines and whether she was taking them as directed. Monitoring adherence to treatment is particularly relevant because Patient V.D.C. had a history of drug abuse and was getting prescriptions from an additional physician for a period of time after Respondent began treating her.

86. Respondent engaged in a departure from the standard of care in his care and treatment of Patient V.D.C. in that he failed to provide proper oversight in order to monitor her use of controlled substances.

**Patient M.L.**

87. Patient M.L. is a 30-year-old man with a history of traumatic injuries in 2000 and 2006 related to motor vehicle accidents. In 2000, he fractured his right heel and left ankle. In 2006, he fractured his right elbow. These fractures required surgical intervention including placement of hardware to fix the fractures.

88. On or about September 6, 2012, Patient M.L. first presented to Respondent for pain management and indicated pain in his arms, back, and feet. He was noted to be taking methadone 10 mg. and hydromorphone 8 mg. and receiving monthly quantities of 90 and 240, respectively. The patient described himself as unemployed and as having learned of Respondent’s practice via “drive by.” Substance abuse history is not noted on the health history form, as that section of the form is left blank. There is a urine drug screen from September 6, 2010, that was positive for methadone and morphine, which was inconsistent with what the patient was reportedly taking, though there is some mention on the history form of the patient having “used morphine.” Earlier in the chart the patient is described as a nonsmoker.

89. There is a physical examination with the initial visit. It is a checkbox format with a few handwritten notes. On the right side of the page, there appears to be a recommendation for
foot and ankle x-rays. The diagnosis appears to be chronic pain due to ankle and vertebral fractures.

90. There is a consent form for chronic opioid therapy and a pain management agreement corresponding to the initial visit. The treatment objectives are not delineated in the handwritten notes but can be gleaned from these two forms.

91. There is no indication Respondent checked a CURES report in conjunction with the initial visit. The CURES report for Patient M.L. covering the time frame of July 9, 2010, through July 9, 2013, shows that he first filled prescriptions from Respondent on September 21, 2012, for hydromorphone 8 mg. # 56 and September 22, 2012, for methadone 10 mg. # 112. The next prescriptions are not until mid-December 2012.

92. Respondent engaged in a departure from the standard of care with respect to his evaluation of Patient M.L. prior to prescribing controlled substances for pain primarily due to the absence of a substance abuse history in this young man who was taking high dose opioid medication.

93. Respondent continued to treat Patient M.L. and see him in follow-up approximately monthly. He obtained multiple urine drug screens to monitor the patient’s adherence to treatment with controlled substances. It is notable that the patient tested positive for morphine even though that is not a prescribed medicine. On two tests, the patient tested positive for benzodiazepine, which is not a prescribed medicine. On another test, Patient M.L. tested negative for a prescribed medication, hydromorphone. There is nothing in Respondent’s notes attempting to reconcile these aberrant drug screen findings to the extent that they potentially impact whether Respondent continues or modifies the patient’s treatment with controlled substances.

94. Respondent engaged in a departure from the standard of care with respect to his monitoring of Patient M.L.’s use of controlled substances by not assessing the significance of his aberrant drug screens and reassessing his treatment plan.

Patient G.G.

95. Complainant re-alleges paragraphs 46 through 49, inclusive above, incorporated by reference as if fully set forth herein.
96. Respondent engaged in a departure from the standard of care in his care and treatment of Patient G.G. in that he failed to provide proper oversight in order to monitor his use of controlled substances.

97. Respondent engaged in a departure from the standard of care in his care and treatment of Patient G.G. in that he failed to perform an appropriate examination prior to prescribing controlled substances.

98. Respondent engaged in a departure from the standard of care when he failed to establish a medical indication for the prescription of controlled substances for the patient.

Patient J.G.

99. Complainant re-alleges paragraphs 50 through 73, inclusive above, and incorporates them by reference as if fully set forth herein.

100. Respondent engaged in a departure from the standard of care in his care and treatment of Patient J.G. in that he failed to provide proper oversight in order to monitor the patient’s use of controlled substances.

THIRD CAUSE FOR DISCIPLINE
(Excessive Prescribing)
[Bus. & Prof. Code, § 725]

101. Respondent is subject to disciplinary action under section 725 of the Code in that he committed unprofessional conduct by repeatedly prescribing clearly excessive amounts of controlled substances to Patients V.D.C., G.G., and J.G. The circumstances are as follows.

102. Complainant re-alleges paragraphs 41 through 72, inclusive above, which are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Prescribing to an Addict)
[Bus. & Prof. Code, § 2241]

103. Respondent is subject to disciplinary action under section 2241 of the Code in that he prescribed controlled substances to Patient J.G., a person he reasonably knew was using the drugs for a nonmedical purpose. The circumstances are as follows:

104. Complainant re-alleges paragraphs 50 through 73, inclusive above, which are incorporated by reference as if fully set forth herein.
DISCIPLINE CONSIDERATIONS

105. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on January 30, 2008, in a prior disciplinary action entitled, "In the Matter of the First Amended Accusation Against Gary R. Johnson, M.D.," (Case No. 02-2007-182803), the Board revoked Respondent’s certificate, stayed the revocation and placed Respondent on probation for five years on certain conditions. The discipline was based on violations of Business and Professions Code sections 2280, practice of medicine under the influence of a narcotic drug; 2238, subdivision (a), use/self-prescribing/administering to himself a controlled substance; 2239, subdivision (a), use of a dangerous drug in a dangerous or injurious manner; and 2234, general unprofessional conduct. That decision is now final and is incorporated by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G27755, issued to Gary Ronald Johnson, M.D.;
2. Revoking, suspending or denying approval of Gary Ronald Johnson, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;
3. Ordering Gary Ronald Johnson, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: November 20, 2014

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

Decision - First Amended Accusation No. 02-2007-182803
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:
GARY R. JOHNSON, M.D.
Physician's and Surgeon's Certificate No. G27755
Respondent.

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 30, 2008.

IT IS SO ORDERED December 31, 2007.

MEDICAL BOARD OF CALIFORNIA

By: Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
Chair
Panel A
Division of Medical Quality
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation
Against:

GARY R. JOHNSON, M.D.
P.O. Box 580
San Andreas, California 95249
Physician and Surgeon's Certificate No. G27755
Respondent.

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

PARTIES

1. Barbara Johnston (Complainant) is the Executive Director of the Medical
Board of California. She brought this action solely in her official capacity and is represented in
this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Jennevee H.
de Guzman, Deputy Attorney General.

2. Respondent Gary R. Johnson, M.D. (Respondent) is represented in this
proceeding by attorney Edward A. Hinshaw, Esq., whose address is Hinshaw, Draa, Marsh, Still
& Hinshaw, 12901 Saratoga Avenue, Saratoga, California 95070-9998.
3. On or about August 12, 1974, the Medical Board of California issued Physician and Surgeon’s Certificate No. G27755 to Gary R. Johnson, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 02-2007-182803 and will expire on August 31, 2008, unless renewed. On May 24, 2007, an interim suspension order was issued pursuant to Government Code section 11529, suspending Physician and Surgeon’s Certificate No. G27755.

JURISDICTION

4. First Amended Accusation No. 02-2007-182803 was filed before the Division of Medical Quality (Medical Board of California) for the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on August 24, 2007. Respondent timely filed his Notice of Defense contesting the First Amended Accusation. A copy of First Amended Accusation No. 02-2007-182803 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in First Amended Accusation No. 02-2007-182803. Respondent has also carefully read, discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent is also fully aware of his legal right to petition for penalty relief pursuant to Business and Professions Code sections 2221, subdivision (b) and 2307.
8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

**CULPABILITY**

9. Respondent admits to the truth of the allegations contained in the Fourth and Fifth Causes for Discipline in First Amended Accusation No. 02-2007-182803. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the allegations contained in the First, Second, Third and Sixth Causes for Discipline in First Amended Accusation No. 02-2007-182803 and that he has thereby subjected his license to discipline.

10. Respondent agrees that his Physician and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Division of Medical Quality (Medical Board of California)'s imposition of discipline as set forth in the Disciplinary Order below.

**CONTINGENCY**

11. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Medical Board of California regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Medical Board of California considers and acts upon it. If the Medical Board of California fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Medical Board of California shall not be disqualified from further action by having considered this matter.

**OTHER MATTERS**

12. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.
DISCIPLINARY ORDER

In consideration of the foregoing admissions and stipulations, the parties agree that the Medical Board of California may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

IT IS HEREBY ORDERED that Physician and Surgeon's Certificate No. G27755 issued to Respondent Gary R. Johnson, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES** Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnoses for which the controlled substance was furnished.

   Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Division or its designee at all times during business hours and shall be retained for the entire term of probation.

   Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

2. **CONTROLLED SUBSTANCES - ABSTAIN FROM USE** Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does
not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the Division or its designee of the: issuing practitioner’s name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number.

3. **ALCOHOL - ABSTAIN FROM USE**  Respondent shall abstain completely from the use of products or beverages containing alcohol.

4. **BIOLOGICAL FLUID TESTING**  Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.

5. **PRESCRIBING PRACTICES COURSE**  Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent’s expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. **MEDICAL RECORD KEEPING COURSE**  Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping,
at respondent’s expense, approved in advance by the Division or its designee. Failure to
successfully complete the course during the first 6 months of probation is a violation of
probation.

A medical record keeping course taken after the acts that gave rise to the charges
in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole
discretion of the Division or its designee, be accepted towards the fulfillment of this condition if
the course would have been approved by the Division or its designee had the course been taken
after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division
or its designee not later than 15 calendar days after successfully completing the course, or not
later than 15 calendar days after the effective date of the Decision, whichever is later.

7. PSYCHIATRIC EVALUATION  Within 30 calendar days of the effective
date of this Decision, and on whatever periodic basis thereafter may be required by the Division
or its designee, respondent shall undergo and complete a psychiatric evaluation (and
psychological testing, if deemed necessary), which will also include an evaluation for substance
abuse, by a Division-appointed board certified psychiatrist, who shall consider any information
provided by the Division or designee and any other information the psychiatrist deems relevant,
and shall furnish a written evaluation report to the Division or its designee. Psychiatric
evaluations conducted prior to the effective date of the Decision shall not be accepted towards
the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations
and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the
evaluating psychiatrist, including any recommendations for psychotherapy and/or participation in
a Diversion-type program, within 15 calendar days after being notified by the Division or its
designee. Failure to undergo and complete a psychiatric evaluation and psychological testing, or
comply with the required additional conditions or restrictions, is a violation of probation.

Respondent shall not engage in the practice of medicine until notified by the
Division or its designee that respondent is mentally fit to practice medicine safely. The period of
time that respondent is not practicing medicine shall not be counted toward completion of the
term of probation.

8. MEDICAL EVALUATION AND TREATMENT  Within 30 calendar
days of the effective date of this Decision, and on a periodic basis thereafter as may be required
by the Division or its designee, respondent shall undergo a medical evaluation by a
Division-appointed physician who shall consider any information provided by the Division or
designee, and any other information the evaluating physician deems relevant, and shall furnish a
medical report to the Division or its designee.

Following the evaluation, respondent shall comply with all restrictions or
conditions recommended by the evaluating physician within 15 calendar days after being notified
by the Division or its designee.

If respondent is required by the Division or its designee to undergo medical
treatment, respondent shall, within 30 calendar days of the requirement notice, submit to the
Division or its designee for prior approval the name and qualifications of a treating physician of
respondent's choice. Upon approval of the treating physician, respondent shall within 15
calendar days undertake medical treatment and shall continue such treatment until further notice
from the Division or its designee.

The treating physician shall consider any information provided by the Division or
its designee or any other information the treating physician may deem pertinent prior to
commencement of treatment. Respondent shall have the treating physician submit quarterly
reports to the Division or its designee indicating whether or not the respondent is capable of
practicing medicine safely. Respondent shall provide the Division or its designee with any and
all medical records pertaining to treatment that the Division or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically
incapable of resuming the practice of medicine without restrictions, the Division shall retain
continuing jurisdiction over respondent’s license, and the period of probation shall be extended
until the Division determines that respondent is physically capable of resuming the practice of
medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and
Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.

Respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of its determination that he is medically fit to practice safely.

9. **NOTIFICATION** Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and First Amended Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10. **SUPERVISION OF PHYSICIAN ASSISTANTS** During probation, respondent is prohibited from supervising physician assistants.

11. **OBEY ALL LAWS** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

12. **QUARTERLY DECLARATIONS** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. **PROBATION UNIT COMPLIANCE** Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code
Respondent shall not engage in the practice of medicine in his place of residence.

Respondent shall maintain a current and renewed California physician’s and surgeon’s license.

Respondent shall immediately inform the Division, or its designee, in writing of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

14. INTERVIEW WITH THE DIVISION OR ITS DESIGNEE. Respondent shall be available in person for interviews either at his place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

15. RESIDING OR PRACTICING OUT-OF-STATE. In the event respondent should leave the State of California to reside or to practice, he shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this and the following terms and conditions: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent’s license shall be automatically cancelled if respondent’s periods of temporary or permanent residence or practice outside California total two years. However, respondent’s license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date
probation is completed or terminated in that state.

16. **FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT**

   In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

   All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

   Respondent’s license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

17. **COMPLETION OF PROBATION**  Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

18. **VIOLATION OF PROBATION**  Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.
19. LICENSE SURRENDER  Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent’s license. The Division reserves the right to evaluate respondent’s request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent’s wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent’s license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

20. PROBATION MONITORING COSTS  Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $3,173.00, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.
ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Edward A. Hinshaw, Esq. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 11/20/07

[Signature]

GARY R. JOHNSON, M.D. (Respondent)

I have read and fully discussed with Respondent Gary R. Johnson, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.


[Signature]

EDWARD A. HINSHAW, ESQ.
Attorney for Respondent
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: ____-__-__

EDMUND G. BROWN JR., Attorney General of the State of California

GAIL M. HEPELL
Supervising Deputy Attorney General

JENNEVEE H. DE GUZMAN
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: SA2007301769
stipulation.wpd
Exhibit A
First Amended Accusation No. 02-2007-182803
In the Matter of the First Amended Accusation Against:

GARY R. JOHNSON, M.D.
P.O. Box 580
San Andreas, California 95249
Physician and Surgeon's Certificate No. G27755
Respondent.

Complainant alleges:

1. Barbara Johnston (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 12, 1974, the Medical Board of California issued Physician and Surgeon's Certificate Number G27755 to Gary R. Johnson, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2008, unless renewed. On May 24, 2007, an interim suspension order was issued pursuant to Government Code section 11529, suspending the license.
3. This First Amended Accusation is brought before the Division of Medical Quality (Medical Board of California) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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

5. Section 2004 of the Code states:

"The Division of Medical Quality shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

6. Section 2234 of the Code states in pertinent part as follows:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct."

7. Section 2238 provides that "[a] violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

8. Subdivision (a) of section 2239 provides as follows:

"The use or prescribing for or administering to himself or herself, of any
controlled substance; or the use of any of the dangerous drugs specified in Section
4022, or of alcoholic beverages, to the extent, or in such a manner as to be
dangerous or injurious to the licensee, or to any other person or to the public, or to
the extent that such use impairs the ability of the licensee to practice medicine
safely or more than one misdemeanor or any felony involving the use,
consumption, or self-administration of any of the substances referred to in this
section, or any combination thereof, constitutes unprofessional conduct. The
record of the conviction is conclusive evidence of such unprofessional conduct.”

9. Section 2266 provides that the “failure of a physician and surgeon to
maintain adequate and accurate records relating to the provision of services to their patients
constitutes unprofessional conduct.”

10. Section 2280 provides that no licensee shall practice medicine while under
the influence of any narcotic drug or alcohol to such an extent as to impair his or her ability to
conduct the practice of medicine with safety to the public and his or her patients. Violation of
this section constitutes unprofessional conduct and is a misdemeanor.

11. Section 4022 provides as follows:

“‘Dangerous drug’ or ‘dangerous device’ means any drug or device unsafe
for self-use in humans or animals, and includes the following:

“(a) Any drug that bears the legend: ‘Caution: federal law prohibits
dispensing without prescription,’ ‘Rx only,’ or words of similar import.

“(b) Any device that bears the statement: ‘Caution: federal law restricts
this device to sale by or on the order of a _________,’ ‘Rx only,’ or words of
similar import, the blank to be filled in with the designation of the practitioner
licensed to use or order use of the device.

“(c) Any other drug or device that by federal or state law can be lawfully
dispensed only on prescription or furnished pursuant to Section 4006.”

12. Section 4076 provides in pertinent part as follows:

“(a) A pharmacist shall not dispense any prescription except in a container
that meets the requirements of state and federal law and is correctly labeled with all of the following:

“(1) Except where the prescriber . . . orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

“(2) The directions for the use of the drug.

“(3) The name of the patient or patients.

“(4) The name of the prescriber . . .

“(5) The date of issue.

“(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

“(7) The strength of the drug or drugs dispensed.

“(8) The quantity of the drug or drugs dispensed.

“(9) The expiration date of the effectiveness of the drug dispensed.

“(10) The condition for which the drug was prescribed if requested by the patient and the condition is indicated on the prescription.

“(11)(A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

“(i) Prescriptions dispensed by a veterinarian.

“(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

“(iii) Dispensed medications for which no physical description exists in any commercially available database.

“(B) This paragraph applies to outpatient pharmacies only.
“(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

“(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.”

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13. Section 4077 provides in pertinent part as follows:

“(a) Except as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076.

“(b) Physicians, dentists, podiatrists, and veterinarians may personally furnish any dangerous drug prescribed by them to the patient for whom prescribed, provided that the drug is properly labeled to show all information required in Section 4076 except the prescription number.

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“(d) The following notification shall be affixed to all quantities of dimethyl sulfoxide (DMSO) prescribed by a physician, or dispensed by a pharmacy pursuant to the order of a physician in California: "Warning: DMSO may be hazardous to your health. Follow the directions of the physician who prescribed the DMSO for you."

“(e) The label of any retail package of DMSO shall include appropriate precautionary measures for proper handling and first aid treatment and a warning statement to keep the product out of reach of children.”

14. Section 4081 provides in pertinent part as follows:

“(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept
by every... physician, ... holding a currently valid and unrevoked certificate, ...

who maintains a stock of dangerous drugs or dangerous devices.”

15. Section 4170 provides in pertinent part as follows:

“(a) No prescriber shall dispense drugs or dangerous devices to patients
in his or her office or place of practice unless all of the following conditions are met:

“(1) The dangerous drugs or dangerous devices are dispensed to the
prescriber's own patient, and the drugs or dangerous devices are not furnished by a
nurse or physician attendant.

“(2) The dangerous drugs or dangerous devices are necessary in the
treatment of the condition for which the prescriber is attending the patient.

“(3) The prescriber does not keep a pharmacy, open shop, or drugstore,
advertised or otherwise, for the retailing of dangerous drugs, dangerous devices,
or poisons.

“(4) The prescriber fulfills all of the labeling requirements imposed upon
pharmacists by Section 4076, all of the recordkeeping requirements of this
chapter, and all of the packaging requirements of good pharmaceutical practice,
including the use of childproof containers.

“(5) The prescriber does not use a dispensing device unless he or she
personally owns the device and the contents of the device, and personally
dispenses the dangerous drugs or dangerous devices to the patient packaged,
labeled, and recorded in accordance with paragraph (4).

“(6) The prescriber, prior to dispensing, offers to give a written
prescription to the patient that the patient may elect to have filled by the prescriber
or by any pharmacy.

“(7) The prescriber provides the patient with written disclosure that the
patient has a choice between obtaining the prescription from the dispensing
prescriber or obtaining the prescription at a pharmacy of the patient's choice.

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“(b) The Medical Board of California ... shall have authority with the
California State Board of Pharmacy to ensure compliance with this section, and ... [is] ... specifically charged with the enforcement of this chapter with respect to their respective licensees.

“(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, ..., and who is duly registered by the Medical Board of California, ... ."

16. Section 4172 provides that “[a] prescriber who dispenses drugs pursuant to Section 4170 shall store all drugs to be dispensed in an area that is secure. The Medical Board of California shall, by regulation, define the term ‘secure’ for purposes of this section.”

17. California Code of Regulations, title 16, section 1356.3 provides that “[f]or purposes of section 4172 of the code, the phrase ‘area which is secure’ means a locked storage area within a physician's office. The area shall be secure at all times. The keys to the locked storage area shall be available only to staff authorized by the physician to have access thereto.”

18. Health and Safety Code section 11056, subdivision (e)(4) provides that Vicodin is a Schedule III controlled substance.

19. Health and Safety Code section 11190 provides as follows:

“(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

“(1) The name and address of the patient.
“(2) The date.
“(3) The character, including the name and strength, and quantity of controlled substances involved.

“(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

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"(c)(1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

"(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

"(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

"(C) NDC (National Drug Code) number of the controlled substance dispensed.

"(D) Quantity of the controlled substance dispensed.

"(E) ICD-9 (diagnosis code), if available.

"(F) Number of refills ordered.

"(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

"(H) Date of origin of the prescription.

"(2)(A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

"(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

"(d) This section shall become operative on January 1, 2005.

"(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:
“(1) The dispensing of a controlled substance in a quantity limited
to an amount adequate to treat the ultimate user involved for 48 hours or less.
“(2) The administration or dispensing of a controlled substance in
accordance with any other exclusion identified by the United States Health and
Human Service Secretary for the National All Schedules Prescription Electronic
“(f) Notwithstanding paragraph (2) of subdivision (c), the reporting
requirement of the information required by this section for a Schedule II or
Schedule III controlled substance, in a format set by the Department of Justice
pursuant to regulation, shall be on a monthly basis for all of the following:
“(1) The dispensing of a controlled substance in a quantity limited
to an amount adequate to treat the ultimate user involved for 48 hours or less.
“(2) The administration or dispensing of a controlled substance in
accordance with any other exclusion identified by the United States Health and
Human Service Secretary for the National All Schedules Prescription Electronic
Reporting Act of 2005.”

20. Health and Safety Code section 11192 provides as follows:
“In a prosecution for a violation of Section 11190, proof that a defendant
received or has had in his possession at any time a greater amount of controlled
substances than is accounted for by any record required by law or that the amount
of controlled substances possessed by a defendant is a lesser amount than is
accounted for by any record required by law is prima facie evidence of a violation
of the section.”

FIRST CAUSE FOR DISCIPLINE
(Practice of Medicine While Under the Influence of a Narcotic Drug)
[Bus. & Prof. Code, § 2280]
21. Respondent is subject to disciplinary action under section 2280 of the
Code in that he practiced medicine while under the influence of a narcotic drug[s], to wit
///
Vicodin, to such an extent as to impair his ability to conduct the practice of medicine with safety
to the public and his patients. The circumstances are as follows:

22. Shipping records from Henry Schein, Inc., a worldwide distributor of
medical products, services and supplies, show that Respondent received bulk bottles of Vicodin
on the following dates: (1) June 30, 2004; (2) March 11, 2005; (3) June 23, 2005; (4) November
28, 2005; (5) March 22, 2006; (6) June 2, 2006; and (7) February 27, 2007. Each bottle
contained 500 pills.

23. Vicodin is a Schedule III controlled substance and narcotic.

24. The first six shipments of Vicodin are unaccounted for. The February 27, 2007, shipment of Vicodin was kept in Respondent’s home.

25. From February through March 2007, multiple incident reports were filed
against Respondent at Mark Twain St. Joseph’s Hospital, where he held hospital privileges, due
to his verbally abusive and bizarre behavior toward hospital staff and patients. On one occasion,
Respondent appeared disheveled and was incoherent. A hospital staff member asked him to have
a seat in the lounge and Respondent accused her of trying to kill the patients and left. The staff
member believed that Respondent was under the influence of something other than alcohol. Also
during this time, Respondent wrote inappropriate comments regarding the nursing staff in the
patient charts and made inappropriate and derogatory comments about the hospital during
procedures while the patients were awake and alert. In one other incident, Respondent called the
nurses station and gave “Doctor’s Orders” to a nurse for 1 ½ hours regarding two patients despite
the fact the nurse had advised him that she had four patients who needed care. Respondent then
arrived at the hospital just ten minutes later.

26. In addition to the above-described behavior, Respondent conducted his
rounds at odd hours, i.e. from midnight to 2:00 a.m. and discharged three patients in the middle
of the night. Other incidents involved ordering medications for the incorrect dosage, yelling at
nurses, ordering the incorrect tests, complaining in front of patients, making rude comments,
violating patient privacy rights, and calling staff incompetent.

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27. Respondent was suspended from Mark Twain St. Joseph's Hospital on March 22, 2007, because of his bizarre and hostile behavior towards hospital staff and patients.

28. Respondent's conduct constitutes unprofessional conduct in that he practiced medicine while under the influence of a narcotic drug[s], to wit Vicodin, to such an extent as to impair his ability to conduct the practice of medicine with safety to the public and his patients within the meaning of section 2280 of the Code.

SECOND CAUSE FOR DISCIPLINE
(Use/Self-Prescribing/Administering to Himself of a Controlled Substance)
[Bus. & Prof. Code, § 2239(a)]

29. Respondent is subject to disciplinary action under section 2239, subdivision (a), of the Code in that he used, self-prescribed and/or administered to himself a controlled substance[s], to wit, Vicodin. The circumstances are as follows:

30. Complainant re-alleges paragraphs 22 through 27 above, as if fully set forth at this point.

31. Respondent's use, self-prescribing and/or administering to himself a controlled substance[s], to wit Vicodin, constitutes unprofessional conduct within the meaning of Code section 2239, subdivision (a) of the Medical Practice Act.

THIRD CAUSE FOR DISCIPLINE
(Use of a Dangerous Drug in a Dangerous or Injurious Manner &/or Use of a Dangerous Drug to the Extent that Such Use Impairs the Ability of the Licensee to Practice Medicine Safely)
[Bus. & Prof. Code, § 2239(a)]

32. Respondent is subject to disciplinary action under section 2239, subdivision (a) in that he used a dangerous drug, to wit Vicodin, in a manner dangerous or injurious to himself or to any other person and/or to the extent that such use impaired his ability to practice medicine safely. The circumstances are as follows:

33. Complainant re-alleges paragraphs 22 through 27 above, as if fully set forth at this point.

34. Respondent's use of a dangerous drug, to wit Vicodin, in a manner dangerous or injurious to himself or to any other person and/or to the extent that such use
impaired his ability to practice medicine safely constitutes unprofessional conduct within the meaning of Code section 2239, subdivision (a) of the Medical Practice Act.

FOURTH CAUSE FOR DISCIPLINE
(Violation of Drug Statutes)

35. Respondent is subject to disciplinary action under section 2238 of the Code in that he violated various state and federal drug statutes regulating dangerous drugs or controlled substances. The circumstances are as follows:

36. Complainant re-alleges paragraphs 22 through 24 above, as if fully set forth at this point.

37. On May 1, 2007, Senior Investigator Anna Vanderveen (Sr. Inv. Vanderveen), Medical Board of California, together with Calaveras County Sheriff’s Department detectives conducted a drug audit of Respondent’s office. They were met by Respondent’s office staff who advised them that he was recovering from spine surgery and not expected to practice until June of 2007. Sr. Inv. Vanderveen found numerous medications in an administrative office located in unlocked cabinets and in a closet. A box of Ambien samples was found under the sink in an exam room. Expired samples dating back to 2003 and numerous vials of returned medications from patients were also located. Staff members stated there were no inventory controls for the medications dispensed from the office.

38. Dr. Johnson arrived at the office approximately 45 minutes later. Sr. Inv. Vanderveen asked Respondent about the bulk Vicodin and was told that there was no Vicodin in his office. She asked him what it was used for, and he explained that he sometimes gave his vasectomy patients Vicodin and that it would be documented in the patient’s charts. When asked to provide one chart reflecting such documentation, he was unable to do so. When asked about the most recent Vicodin delivery, Respondent explained that he had taken it home and planned to put it into envelopes for his patients. Respondent also explained that he has never sent out a monthly report to the California Department of Justice (CURES report) with respect to scheduled drugs dispensed from his office. He also admitted that, when dispensing drugs, he only provides
verbal orders rather than labels. Patients have forgotten the instructions and/or mistakenly stopped taking their medications.

39. Respondent’s failure to dispense dangerous drugs upon prescription in a container correctly labeled with the information required by section 4076 is a violation of sections 4077 and 4170, subdivision (a)(4).

40. Respondent’s failure to keep a current inventory of his stock of dangerous drugs is a violation of section 4081.

41. Respondent’s failure to store his drugs in an area that is secure is a violation of section 4172.

42. Respondent’s failure to maintain records for each prescription of a controlled substance classified in Schedules II, III, and IV and provide such records to the California Department of Justice is a violation of Health and Safety Code section 11190.

43. Respondent’s violation of the above-referenced state and federal drug statutes regulating dangerous drugs or controlled substances constitutes unprofessional conduct within the meaning of section 2238 of the Medical Practice Act.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)
[Bus. & Prof. Code, § 2266]

44. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records. The circumstances are as follows:

45. Complainant re-alleges paragraphs 22 through 24 and 37 through 38, above, as if fully set forth at this point.

46. Respondent's failure to maintain adequate and accurate records constitutes unprofessional conduct within the meaning of section 2266 of the Medical Practice Act.

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SIXTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)
[Bus. & Prof. Code, § 2234]

47. Respondent is subject to disciplinary action under section 2234 of the Code in that he engaged in verbally abusive and bizarre behavior towards Mark Twain Saint Joseph’s Hospital staff and patients. The circumstances are as follows:

48. Complainant re-alleges paragraphs 25 through 27 above, as if fully set forth at this point.

49. Respondent’s verbally abusive and bizarre behavior towards Mark Twain Saint Joseph’s Hospital staff and patients constitutes unprofessional conduct within the meaning of section 2234.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon’s Certificate Number G27755, issued to Gary R. Johnson, M.D.;

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

3. Ordering Gary R. Johnson, M.D. to pay the Division of Medical Quality, if placed on probation, the costs of probation monitoring; and

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

DATED: August 24, 2007

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant