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

In the Matter of the Accusation Against: **Emmett Chase, M.D.** **PO Box 1288** **535 Airport Road** **Hoopa, CA 95546-1288** **Physician's and Surgeon's Certificate No. G 51614 ,** Respondent.	Case No. 800-2018-045900 **A C C U S A T I O N**

PARTIES

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

2. On or about November 14, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number G 51614 to Emmett Chase, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2023, unless renewed.

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JURISDICTION

3. 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.

4. Section 2234 of the Code, in pertinent part, 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.

. . .

5. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

6. Section 2228.1 of the Code provides, in pertinent part, that the Board shall require a licensee who is disciplined based on inappropriate prescribing resulting in harm to patients, to disclose to his or her patients' information regarding his or her probation status. The license is required to disclose: Probation status, the lengthy of the probation, the probation end date, all practice restrictions placed on the license by the Board, the Board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the Board's Internet Web site.

RESPONDENT'S PRACTICE

7. At the time of the events alleged in this Accusation, Respondent practiced as a primary care physician in Hoopa Valley, California. Respondent provided medical treatment at a clinic run by the Indian Health Service. Respondent withdrew from clinical practice in July 2019.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence)

Patient 1[1]

8. Respondent assumed care for Patient 1 in 2017. Patient 1 was a 65-year-old man with severe chronic low back pain, bilateral lumbar radicular pain, obesity, and hypertension. He had sustained multiple injuries in a motorcycle accident and had been prescribed opioid medications for many years. At the time Respondent began to treat Patient 1, he was receiving more than 200 morphine milligram equivalents per day.[2] Medical records available to Respondent from Patient 1's previous physician documented a well-organized, thoughtful assessment of the patient that supported and explained the very high dose of opioids that were prescribed, and reflected coordination with a consulting pain specialist. The plan was to try to reduce the patient's MME/d. In May 2017, Patient 1 requested to transfer his care to Respondent.

[1] Patients are referred to by number to protect privacy.

[2] Opioid dosage is often discussed in terms of "morphine milligram equivalents", or MME. MME per day, MME/d, is a standard measure of the daily dose of any opioid The MME of morphine is one, meaning that morphine is exactly as potent as morphine. MMEs greater than one signify greater potency, while MMEs less than one signify lesser potency. At the time of the events alleged in this Accusation, the standard of care has been to limit opioid dose to less than 50 MME/d in almost all patients, and to exceed 90 MME/d in only the most unusual circumstances and with only the most careful documentation.

9. Respondent noted regular visits with Patient 1 beginning in June 2017. His note of the initial June 16, 2017 visit contained no documented history of pain, and no other meaningful assessment of the patient. Several weeks later, Respondent's July 10, 2017 physical examination was limited to "NAD BMI elevation. Pain level 6 but no discomfort during visit." Respondent's plan was simply refill pain medication when due.

10. Respondent saw the patient regularly and refilled prescriptions for various controlled substances. His medical record for Patient 1 consists of brief notations, routinely lacking in significant discussion of the patient's complaints, his response to treatment or the rationale for prescribing. His medical records lack a meaningful assessment of the patient's complaints, and the chart does not accurately or adequately list the patient's medications. For example, in August 2017, Respondent documented a discussion of returning to the "original dose" of Norco[3] although there was no record the patient had been prescribed Norco. Respondent regularly prescribed large amounts of Dilaudid[4] and Fentanyl[5] in amounts of approximately 200 MME/d. In October 2017, Respondent doubled Patient 1's dose of Elavil[6] for apparent depression, but did not document any assessment of the patient's depression or rationale for prescribing to treat depression. In September 2018, Respondent noted that a pharmacist refused to refill Patient 1's prescriptions because the dose was so high. The pharmacist attempted to discuss concerns with Respondent, who instead, simply routed Patient 1's prescriptions to a different, more remote pharmacy without any assessment or evaluation of the concerns raised. At no time did Respondent document a clinical rational for prescribing in an amount more than two times the maximum opioid dose recommendation by the Centers for Disease Control.

11. In January 2019, Patient 1 expressed a desire to cut back on Duragesic and increase Dilaudid. Respondent stated in his interview with the Board's investigators that he believed he

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[3] Norco is a trade name for hydrocodone bitartrate with acetaminophen. Hydrocodone Bitartrate is semisynthetic narcotic analgesic and a Schedule III controlled substance and narcotic.

[4] Dilaudid is a trade name for hydromorphone hydrochloride. It is a Schedule II controlled substance and a narcotic.

[5] Fentanyl is an opioid analgesic, and a Schedule II controlled substance. In its transdermal patch for, it is known as Duragesic.

[6] Elavil is a tricyclic antidepressant. It should be used with caution when consuming alcohol.

was tapering Patient 1's Dilaudid by January 2019, and that he had the patient down to 4 pills a day. His medical records at that time indicated he was prescribing 128 tables for 28 days, which would have indicated a tapering of the medication. However, CURES[7] data demonstrates that after 128 tablets of Dilaudid were issued on January 18, 2019, a prescription for 140 tablets was issued on February 11, 2019. The dosage of Dilaudid was never changed, and was constant at 5 to 5.7 tablets per day from late 2018 until the end of his treatment with Respondent in February 2019. Similarly, Respondent prescribed high dosages of fentanyl continuously from October 2017 until the end of treatment. Respondent's note of a March 6, 2019 visit simply stated that the patient was there for a refill of pain medication. No medication names or dosages were documented. Respondent discontinued Duragesic after a final prescription on February 4, 2019, without comment,

12. When asked in his interview by a Board investigator why he did not attempt to treat Patient 1's pain with agents other than opioids, such as non-steroidal anti-inflammatories and gabapentin[8], Respondent was not able to articulate a reason and demonstrated a lack of knowledge about the use of these agents.

13. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 1, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, including but not limited to the following:

A. Respondent prescribed dangerous drugs and controlled substances, without an appropriate evaluation and history and without assessment of the indication for the medications.

B. Respondent prescribed controlled substances in extremely high amounts without documentation of any physical examination to support the care provided, or rationale for the large dosages prescribed.

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[7] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances.

[8] Gabapentin is an antiepileptic and is also used to treat pain.

C. Respondent prescribed narcotics in high dosages without documenting any substance abuse history.

D. Respondent prescribed controlled substances, over a long period of time and in high dosages, without obtaining/and/or documenting informed consent.

E. Respondent prescribed controlled substances, over a long period of time and in high dosages, without documenting a treatment plan with specific treatment goals.

F. Respondent continued to prescribe high dosages of controlled substances, without periodic review or assessment of the efficacy of treatment, even after he was aware of concerns expressed by a pharmacist.

G. Respondent at no time considered or documented a plan to taper Patient 1 off of high dosages of opioid medication, even when he was aware the patient's previous prescriber had recommended a taper.

H. Respondent was unaware of and lacked knowledge of alternatives to opioid treatment for pain.

I. Respondent prescribed and treated Patient 1 without knowledge or information regarding current standards for prescribing opioids.

J. Respondent prescribed Elavil without taking an adequate history and without sufficient indication to support a diagnosis of depression.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence)

Patient 2

14. Patient 2 was a 48-year-old woman with chronic low back and leg pain and multiple medical issues. When she initiated treatment with Respondent, Patient 2 was taking a number of prescribed medications, including Dilaudid, Tizanidine,[9] Elavil, Xanax,[10] and Gabapentin. Respondent began to treat Patient 2 on October 18, 2017.

[9] Tizanidine is a dangerous drug used to treat muscle spasms.

[10] Xanax is a trade name for alprazolam. It is a benzodiazepine and a Schedule IV controlled substance, used to treat anxiety.

15. At the time he commenced treatment, Respondent did not have Patient 2's prior medical records at the initial appointment. Yet Respondent failed to conduct any meaningful history or evaluation of the patient. The entirety of the history he obtained was documented in two sentences, stating only, "Needs hydromorphone and Xanax ASAP. Having swollen left sinus needs treatment- uses Flonase." A cursory and incomplete physical exam was noted, Respondent's assessment was acute sinusitis, anxiety; chronic back pain. His treatment plan consisted of a list of prescribed medications: Xanax ½ of 0.5 mg q d prn #7, Dilaudid 8 mg qid prn, and Zithromax Z-pack. There was no assessment or rationale for the medications prescribed to the patient. Patient 2 was next seen on November 1, 2017, when she requested a "pain shot" and Phenergan[11]. Respondent's cursory exam noted borderline blood pressure and elevated body mass index. His assessment was chronic back pain. He noted an injection of a nonsteroidal anti-inflammatory and an allergy medication. Two weeks later, Respondent prescribed Dilaudid, Tramadol[12], Xanax, and Elavil. Respondent continued to prescribe these medications on a regular basis, but at no time conducted an assessment or evaluation to explain his rational for prescribing or the medical basis for his prescribing.

16. In February 2018, Respondent noted the patient requested that he prescribe a number of medications she was "getting elsewhere." Respondent did not enumerate the medications, or conduct any assessment of the multiple medications his patient was taking. In May 2018, respondent noted that after discussion with pharmacy staff, he believed the patient should be reviewed by a pain committee. Subsequent notes suggest Patient 2 was seen by a pain committee, but Respondent's record contains no assessment or documentation of the recommendations of the committee. In his interview with the Board's investigators, Respondent was unable to articulate what the recommendations of the committee were. Apparently the pain committee recommended a taper of Dilaudid, because Respondent's May 24, 2018 note indicates the patient declined a fentanyl patch, and was in tears due to a reduction in her Diluadid dosage. CURES records indicate that Respondent reduced Patient 2's Diluadid and fentanyl prescriptions significantly,

[11] Phenergan is a trade name for promethazine with codeine cough syrup. It is a controlled substance.

[12] Tramadol, known as Ultram, is a pain medication similar to opioid analgesics.

from 128 MME/d to 62 MME/d, without a taper, in May 2018. CURES records also reflect Respondent prescribed fentanyl in May 2018, but there is no reference to the prescription in Respondent's medical record.

17. In June 2018, Respondent failed to comment on a diluted urine drug screen test, which also showed a drug he had not prescribed, suggesting substance abuse, but instead, without explanation or assessment, increased the dosage of Diluadid back to the original amount. In late June and again in July, Respondent once more reduced the amount of Diluadid, but then increased it in mid-August 2018. Respondent's medical record contains no explanation for the multiple and sudden changes in Patient 2's Diluadid dosage, which caused Patient 2 to experience severe withdrawal symptoms. Even after the patient had a dispute with a pharmacy when she attempted to get an early refill of Diluadid, Respondent conducted no assessment or evaluation of his patient.

18. In November 2018, Patient 2 consulted with a neurosurgeon, who noted aberrant drug behavior, and recommend a pain consultation. At his next visit with the patient on December 21, 2018, Respondent did not follow up on the neurosurgeon's recommendations for alternative pharmacological therapy or referral to a pain management physician, but instead, prescribed Dilaudid. Respondent continued to prescribe Diluadid and Xanax to Patient 2 for months after Respondent had stopped practicing clinical medicine in June 2019.

19. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 2, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, including but not limited to the following:

A. At the first visit, Respondent failed to reconcile and make rational Patient 2's medication list, or to document a rational plan to manage her polypharmacy.

B. Respondent prescribed multiple dangerous drugs and controlled substances, without an appropriate evaluation and history and without assessment of the indication for the medications, and without any evaluation or assessment of the potential for interactions between the medications.

C. Respondent prescribed Diluadid in high quantity, along with numerous other controlled substances, without documentation of any physical examination to support the care provided.

D. Respondent prescribed Diluadid in high dosages without documenting any substance abuse history.

E. Respondent prescribed controlled substances, over a long period of time and in high dosages, without obtaining/and/or documenting informed consent.

F. Respondent prescribed controlled substances, over a long period of time and in high dosages, without documenting a treatment plan with specific treatment goals.

G. Respondent continued to prescribe controlled substances, without periodic review or assessment of the efficacy of treatment, even after he was aware of concerns expressed by a pharmacist, and in spite of recommendations from a pain committee and a consulting neurosurgeon.

H. Respondent made sudden and unexplained changes in Patient 2's Diluadid dosage, without apparent consideration of the impact on the patient, and did not address the patient's apparent withdrawal symptoms.

I. Respondent at no time considered or documented a rational and safe plan to taper Patient 2 off of high dosages of Diluadid, even when it was apparent the patient suffered from withdrawal symptoms and demonstrated aberrant drug behavior.

J. Respondent was unaware of and lacked knowledge of alternatives to opioid treatment for pain.

K. Respondent prescribed and treated Patient 2 without knowledge or information regarding current standards for prescribing opioids.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence)

Patient 3

20. Respondent began to treat Patient 3 in late 2017. Patient 3 was a 52-year-old man who had quadriplegia after a 2007 accident. He had multiple serious chronic conditions, including

pain and anxiety, in addition to social isolation and poverty. At the time he first saw Patient 3, the patient had just been released from a prolonged hospitalization for urosepsis, pneumonia and respiratory failure. Patient 3 was a known abuser of methamphetamine, heroin, and cannabis. Patient 3 was under Respondent's care until May 2019, and transferred to other providers in July 2019.

21. Patient 3's first documented visit with Respondent was on February 15, 2018. Respondent conducted only a cursory evaluation, and his notation included vital signs, and that the patient was "communicative and joking." Respondent indicated he would refill "chronic meds" including Flexeril[13], Norco, and Gabapentin. A February 16, 2018 note included a mediation list which included Klonopin[14], fentanyl, Norco, Flexeril, gabapentin and methadone[15]. Over the following months, the patient requested increased dosages of fentanyl, along with valium[16] to treat leg cramps, and Ativan[17] for anxiety. In September 2018, Patient 3 was admitted to the hospital for altered level of consciousness, and was administered Narcan, a drug used to reverse the effects of opiates.

22. Between February 2018 and continuing until February 2020, Respondent regularly prescribed Duragesic, Methadone, Norco, Ativan and Klonopin. At no time during his treatment of Patient 3 did Respondent ever formulate or document a treatment plan other than refilling various mediations. Respondent at no time conducted or documented a thorough medical history, physical examination, or an assessment and evaluation of the patient's medical conditions, or the rationale behind prescribing three different opioids, combined with benzodiazepines, gabapentin and at times, Flexeril. At no time did Respondent conduct or document a substance abuse history, or evaluate the safety or efficacy of prescribing multiple narcotics -some long acting and some short acting- and benzodiazepines to a known substance abuser. Similarly, Respondent purported to be unaware that toxicological screening in December 2017 revealed a number of non-

[13] Flexeril is used short-term to treat muscle spasms.
[14] Klonopin is a benzodiazepine and a Schedule IV controlled substances.
[15] Methadone is a synthetic narcotic analgesic similar to morphine. It is a Schedule II controlled substance, and should be used with caution in those who are receiving other narcotic analgesics.
[16] Valium is a psychotropic drug and a Schedule IV controlled substance.
[17] Ativan is a benzodiazepine and a Schedule IV controlled substance.

prescribed substances, including codeine/morphine, hydrocodone, benzodiazepines, methamphetamine and heroin. In December 20018, a toxicology test detected non-prescribed benzodiazepines. In April 2019, Patient 3 was diagnosed at a local hospital as having nausea and vomiting due to cannabis hyperemesis syndrome. Respondent at no time evaluated, assessed or apparently even considered the patient's substance abuse or in any manner address the etiology of his symptoms of nausea and vomiting. Similarly, Respondent failed to address or respond to various physical ailments suffered by Patient 3, or even to review and respond to notes or request from public health nursing regarding the patient.

23. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 3, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, including but not limited to the following:

A. Respondent prescribed methadone, fentanyl, Norco, Flexeril, Klonopin and gabapentin to Patient 3 without ever conducing an appropriate evaluation and history and without assessment of the indication for the medications, and without any evaluation or assessment of the potential for interactions between the medications.

B. Respondent prescribed multiple opioids and benzodiazepines to a known substance abuser without ever conducing a substance abuse history or assessment, and without any consideration of the risks posed by such prescribing, and without ever attempting to manage Patient 3's polysubstance use disorder.

C. Respondent prescribed controlled substances, over a long period of time and in high dosages, without obtaining/and/or documenting informed consent.

D. Respondent prescribed controlled substances, over a long period of time and in high dosages, without documenting a treatment plan with specific treatment goals.

E. Respondent failed to review and respond to multiple public health nurse notes regarding Patient 3.

F. Respondent failed to assess, evaluate or respond to Patient 3's multiple medical issues over the course of treatment.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

24. Respondent is guilty of unprofessional conduct and subject to discipline for violation of Sections 2234 and/or 2266 of the Code for failure to keep adequate and accurate medical records for each of the three patients alleged above.

25. In each case, Respondent's medical records fail to include a complete or even partial assessment of the patient's presenting condition, an assessment of the patient, the rationale for prescribing, or response to treatment. Respondent's records regularly stated that a medication had been prescribed for the patient, did not state the medical indication or rational for the prescription. Respondent's records for each patient lack a clear and understandable list of medications prescribed, and it is impossible to determine what medication the patients were on at any given time, at what dosage, or for what reason. Respondent failed to document an appropriate or adequate informed consent was provided to any of the three patients, at any time over the course of treatment, or for the types, amounts and combinations of drugs prescribed.

PRESCRIBING RESULTING IN HARM TO PATIENTS

26. Respondent's patterns of prescribing controlled substances to the three patients described in this Accusation subjected the patients to unnecessary polypharmacy. His indiscriminate and incautious prescribing of controlled medications increased the chance of many adverse outcomes, including adverse drug reactions, adverse drug interactions, falls, cognitive impairment and mortality. Respondent further subjected his patients to an unwarranted risk of harm when he undertook to prescribe controlled substances to treat complex patient conditions, when Respondent lacked the necessary knowledge to appropriately manage these patients. Respondent's irrational and sudden reduction of Patient 2's Dilaudid dose resulted in painful withdrawal symptoms that Respondent did not treat, and apparent self-treatment or diversion.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 51614 , issued to Emmett Chase, M.D.;

2. Revoking, suspending or denying approval of Emmett Chase, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Emmett Chase, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 12 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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