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

In the Matter of the Accusation Against: **DONALD B. HOROWITZ, M.D.** 8632 Archibald Ave, Suite 202 Rancho Cucamonga, CA 91730-4666 Physician's and Surgeon's Certificate No. A 22814, Respondent.	Case No. 13-2013-229938 **A C C U S A T I O N**

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 (Board).

2. On or about June 24, 1968, the Medical Board issued Physician's and Surgeon's Certificate Number A 22814 to Donald B. Horowitz, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges herein and will expire August 31, 2016, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2229 of the Code states, in subdivision (a):

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

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

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[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

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.

". . ."

7. Section 2238 of the Code states:

"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. 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.

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"(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."

9. 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.

"(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 Prevention and Control Act of 1970.

"(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."

10. Section 2242 of the Code states:

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

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

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

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

"(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."

11. 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."

12. 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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. 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:

Patient J.V.

14. On or about January 12, 2010, an initial appointment was scheduled for J.V., a 38-year-old separated male, to see Respondent regarding depression. J.V. was not taking medications at the time, but reportedly had previously taken Trazodone, Effexor and Depakote.

15. On or about January 26, 2010, J.V. appeared for a sixty minute initial appointment with Respondent. On his self-reported patient questionnaire, J.V. listed problems as depression, anxiety, memory loss, back pain. J.V. also wrote that he was "sober 20 days" and worked as an electrician, a lineman. He indicated his chief complaint was depression or bipolar.

16. Respondent noted in his records that the patient "sleeps too much"; had a prior history of alcohol and numerous rehabilitation episodes, and "medical detoxification" twice; that he was sober 20 days; and had a genealogy with many addicted relatives. He diagnosed J.V. with "296.89" (bipolar II) and prescribed Seroquel and Depakote, medications used to treat bipolar disorders. In the course of the next year Abilify and Lexapro were also prescribed, but due to the chaotic state of the clinical record, when and how much of these medications were prescribed is impossible to determine. There is no documentation of laboratory tests including toxicology

evaluations.

17. Over the course of treatment, the handwritten treatment notes of J.V. were extremely chaotic, jumbled, usually illegible, and excluded a copy or complete description of samples or prescriptions given to the patient. There was no assessment of patient J.V.'s safety, suicide risk, comorbid conditions or medical illness(es). There were no toxicology screens from patient J.V., there were no referrals of patient J.V. for appropriate detoxification, and there was no informed consent for the psychotropic medications or controlled substances prescribed to J.V.

18. Although Respondent was aware that J.V. was an addict, he prescribed J.V. excessive medications, including Xanax, Ambien, Valium and Ativan, in excess quantities, without medical indication. He did not track, record or monitor prescriptions to J.V. Sometimes Respondent or patient G.O. (a friend of Patient J.V.) would pick up J.V.'s prescriptions from the pharmacy. Respondent would keep portions of J.V's medications at his various offices. Respondent also used G.O.,[2] as a courier to deliver sedatives to J.V.

19. On or about July 6, 2010, Respondent saw J.V. at an appointment. Records from this visit are illegible and incomplete. Again, Respondent did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances he prescribed to J.V.

20. On or about November 30, 2010, Respondent saw J.V. at an appointment. Records from this visit were again illegible and incomplete. Respondent again did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances he prescribed to J.V.

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[2] G.O. was also a patient of Respondent who received prescriptions for Klonopin, Xanax and Norco.

21. On or about December 14, 2010, Respondent saw J.V. at an appointment. Records from this visit were illegible and incomplete. Respondent again did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances prescribed to J.V. Respondent noted that J.V. had "lost" or "misplaced" his medication, yet Respondent continued to prescribe large quantities of sedatives rather than limiting the supply. Prescriptions included: December 22, 2010, Valium 10 mg, #60; January 5, 2011, Ativan 2 mg, # 60, both benzodiazepines.

22. On or about February 1, 2011, Respondent saw J.V. at an appointment. Records from this visit were illegible and incomplete. Respondent again did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances prescribed to J.V. Prescriptions included: March 12, 2011, Ativan 2 mg, #56.

23. Between March 8, 2010 to March 12, 2011, Respondent prescribed Xanax and Ambien to J.V. in excessive quantities.

24. On or about March 16, 2011, Respondent saw J.V. at an appointment. In the treatment notes, there is no list of current medications, no mental status examination, no evaluation for suicidality or intoxication, no laboratory results, no discussion or assessment.

25. Between March of 2011 and June of 2011, other physicians had been prescribing hydrocodone to J.V. Despite knowing J.V. was an addict, there was no documentation that Respondent inquired or counseled J.V. of the dangers of mixing opioids with benzodiazepines. Respondent did not perform a type of toxicology testing. The listing of prescriptions is incomplete and chaotic. Prescriptions included: March 30, 2011, Xanax 2 mg, #90.

26. On or about May 6, 2011, Respondent saw J.V. at an appointment. Records for this visit were illegible and incomplete. Respondent did not monitor prescriptions to J.V. Respondent

did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances prescribed to J.V. Prescriptions included: May 9, 2011, Xanax 2 mg, #120; Ambien 10 mg, #60; Ativan 2 mg, #120.

27. On or about May 27, 2011, Respondent saw J.V. at an appointment. Records for this visit were illegible and incomplete. Respondent did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, suicide risk, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances prescribed to J.V. Respondent noted that J.V. was having "panic attacks" and Respondent "strongly recommended Ativan." There was no toxicology screening to determine if J.V. was using other drugs (opiates, cannabis). There was no documentation of other medication used from others (opiates). There was no discussion of the risks of interaction of opioids with benzodiazepines.

28. On or about June 3, 2011, Respondent saw J.V. at an appointment. Records from this visit were illegible and incomplete. Respondent did not monitor prescriptions to J.V. Respondent did not assess J.V.'s safety, comorbid conditions or medical illnesses. Respondent did not obtain a toxicology screen from patient J.V. Respondent did not refer patient J.V. for detoxification. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances prescribed to J.V. Respondent noted that J.V. was "extremely withdrawn" and depressed and demanded, "just give me my medication." There was no documentation of suicide risk evaluation. Prescriptions included: June 6, 2011, Ativan 2 mg, #120; Ambien 10 mg, #60, dosage equivalent to 40 mg daily.

29. On or about June 10, 2011, Respondent saw J.V. at an appointment. Records from this visit were illegible and incomplete. J.V.'s prescriptions were not monitored. Respondent did not assess J.V.'s safety, comorbid conditions or medical illnesses. Respondent did not obtain an informed consent for the large amounts of psychotropic medications or controlled substances

prescribed to J.V. Respondent noted that J.V. had "OCD" (obsessive compulsive disorder) because he "can't get out of bed" and had severe anxiety/panic. Respondent offered J.V. "voluntary hospitalization" and perhaps warned him about alcohol. Respondent diagnosed patient J.V. with 296.89 (bipolar II), 300.0 (anxiety) and 300.3 (OCD). There was no discussion of suicide risk in the mental status examination. There was no discussion of sedation from prescription medications as the most likely reason J.V. could not get out of bed. There was no toxicology screen, no discussion of opiate risk or the risk of using high dose sedatives. There was no referral to appropriate detoxification. There was no notation of medications prescribed. Prescriptions included: June 11, 2011, via a phone order: Ambien 10 mg, #120; Ativan 2 mg, #120; and Xanax 2 mg, #24. Both Ativan and Xanax are benzodiazepines, prescribed at high doses.

30. On or about June 17, 2011, J.V. could not be woken after a nap. The cause of his death was determined to be the combined effects of clonazepam,[3] alprazolam,[4] tetrahydrocannabinol,[5] aminoclonazepam,[6] hydroxyalprazolam,[7] and hydrocodone.[8]

31. After J.V. died, his parents ended up receiving a bill for Respondent's services to patient J.V. The patient's mother returned the bill to Respondent by fax with an angry message accusing him of killing her son. Respondent telephoned his patient G.O. and spoke to G.O.'s daughter, gossiping about the cause of patient J.V.'s mental illness. Respondent later spoke to patient G.O. on the phone and agreed that she would calm the anger of J.V.'s parents.

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[3] Clonazepam is generic for the drug Klonopin, belonging to a class of drugs called benzodiazepines. It is a tranquilizer used to treat seizures and panic attacks.

[4] Alprazolam is generic for the drugs Xanax, belonging to a class of drugs called benzodiazepines. Benzodiazepines are in a group of central nervous system depressants which slow down the central nervous system.

[5] Tetrahydrocannabinol (THC) is the active chemical in cannabis and is one of the oldest hallucinogenic drugs known.

[6] Aminoclonazepam is a metabolite of clonazepam (Klonopin).

[7] Hydroxyalprazolam is a major metabolite of alprazolam (Xanax).

[8] Hydrocodone is an opiate agonist, semi-synthetic narcotic analgesic (pain-killer) and antitussive (cough suppressant) used in the treatment of mild to moderate pain. It blocks the receptors on nerve cells in the brain that give rise to the sensation of pain. It is mixed with acetaminophen, a non-narcotic analgesic in brand name medicines Vicodin and Norco.

32. Respondent was grossly negligent in his care and treatment of patient J.V. because he was aware that J.V. was an addict and, without examination or medical indication, Respondent prescribed him excessive medications for over one year.

33. Respondent was grossly negligent in his care and treatment of patient J.V. when he failed to assess or document an assessment of patient J.V.'s safety, suicide risk, comorbid conditions or medical illnesses.

34. Respondent was grossly negligent in his care and treatment of patient J.V. because his prescribing to patient J.V. was prolonged, excessive and careless, and, singularly or collectively, Respondent failed to obtain toxicology screens from patient J.V. and failed to refer patient J.V. for appropriate detoxification.

35. Respondent was grossly negligent in his care and treatment of patient J.V. when he failed to monitor J.V.'s available or accessible quantity of narcotics or sedatives.

36. Respondent was grossly negligent in his care and treatment of patient J.V. as Respondent failed to obtain appropriate informed consents from patient J.V. for the various types and large quantities of medications, either controlled or psychotropic, he prescribed to patient J.V.

37. Respondent was grossly negligent in his care and treatment of patient J.V. when he made and maintained illegible and chaotic medical records and in other instances, failed to make and/or maintain any medical records at all.

38. Respondent was grossly negligent in his care and treatment of patient J.V., taken singularly or collectively, when he violated J.V.'s confidentiality in the following circumstances:

(1) Respondent asked G.O. to deliver sedatives to patient J.V. and made arrangements for her to do so;

(2) After J.V. died, Respondent gossiped about the etiology of J.V.'s emotional problems with G.O.'s daughter on the phone;

(3) After J.V. died and Respondent received a fax from J.V.'s family accusing him of killing their child, Respondent discussed and agreed with G.O. on the telephone that she would calm the anger of J.V.'s parents.

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Patient G.O.

39. About and between November 9, 2010 and December 21, 2011, Respondent treated patient G.O. She had been involved with a former patient of Respondent's. The former patient had a history of drug addiction and Respondent considered him a "drug seeker." Patient G.O. had referred her friend, patient J.V., to Respondent.

40. When required to provide medical records for patient G.O., the only records Respondent produced included a list of office billing codes and dates of visits. No chart notes and no narratives were provided. Patient G.O. observed that Respondent rarely took notes during session appointments. Respondent asserted he had misplaced patient G.O.'s medical records.

41. According to his record, Respondent saw G.O. as a patient on the following dates: November 9, 2010; December 7, 2010; December 21, 2010; January 3, 2011; January 13, 2011; January 27, 2011; March 9, 2011; April 11, 2011; May 12, 2011; June 16, 2011; July 13, 2011; November 4, 2011; and December 21, 2011.

42. At her first appointment, patient G.O. was upset. Respondent went to his car and got some medication. He gave her two pills to take to help her calm down. He often walked out to his car to get sample medications for her. He gave her samples of a variety of sleeping aid medications, including Lunesta, Xanax and Klonopin.

43. Respondent told patient G.O. he had an "arrangement" with a pharmacy. He told her to take her prescription to have it filled at the pharmacy and they would not charge her. He also told her that the prescription would be written for a certain number of tablets, however, the pharmacy would only give her half of the prescription and he would receive the remaining tablets from the pharmacy. Patient G.O. became addicted to the prescription medications that Respondent prescribed to her and she believes Respondent knew she was addicted to the drugs.

44. Patient G.O. would call Respondent for a prescription without having an appointment. Respondent would comply and call in the prescription to the pharmacy or mail her samples. Other times Respondent would give her someone else's prescription with their name scribbled out and G.O.'s name hand-written on the label.

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45. Respondent failed to obtain a proper history from patient G.O. or perform a physical examination on her despite her complaints of pain and his prescribing of narcotics for said pain. Nor did Respondent refer her to another doctor. He performed no diagnostic tests or work up to rule out medical conditions that could have been the source of her complaints of pain.

46. Over the course of her treatment, Respondent prescribed patient G.O. large amounts of Norco, Xanax and Klonopin.

47. On or about November 9, 2010 through December 21, 2011, taken individually or collectively, Respondent was grossly negligent in his care and treatment of patient G.O. when he:

(1) failed to maintain adequate and accurate records pertaining to the provision of services he provided to patient G.O.;

(2) prescribed patient G.O. controlled substances without a prior examination or without medical indication.

Patient A.R.

48. Patient A.R. was a twenty year-old female student who had a single appointment with Respondent on May 23, 2014. The appointment was scheduled for 4:15 p.m. but Respondent was late and she was made to wait a lengthy period of time before the scheduled appointment began.

49. Patient A.R. had completed forms and questionnaires neatly. One was a depression self-rating test. Patient A.R. had indicated that she recently had significant suicidal ideation. Specifically, choosing the best response that described her in the past seven days, she checked off "I think of suicide or death several times a week for several minutes." Respondent scored A.R.'s depression self-rating test as "severe," one point away from "very severe."

50. After her appointment began, she observed that Respondent fell asleep frequently during the visit while she spoke. Eventually, he interrupted the appointment and declared that he was going to get a haircut. He invited her to accompany him to the barber where she could continue talking or that she could wait until he completed getting his haircut and then continue with her appointment. The patient initially agreed to wait to complete the appointment but finally left.

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51. On or about May 23, 2014, taken individually or collectively, Respondent was grossly negligent in his care and treatment of patient A.R.:

(1) when he continued to treat A.R. while he was impaired after he had fallen asleep during the appointment; and

(2) when he told A.R. that the session would stop until he first got a haircut and the session would resume after the haircut.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

Patient J.V.

53. The facts and circumstances as alleged in paragraphs 14 through 31 are incorporated here as if fully set forth.

54. Respondent was negligent in his care and treatment of patient J.V. because he was aware that J.V. was an addict and, without examination or medical indication, Respondent prescribed him excessive medications for over one year.

55. Respondent was negligent in his care and treatment of patient J.V. when he failed to assess or document an assessment of patient J.V.'s safety, suicide risk, comorbid conditions or medical illnesses.

56. Respondent was negligent in his care and treatment of patient J.V. because his prescribing to patient J.V. was prolonged, excessive and careless, and, singularly or collectively, Respondent failed to obtain toxicology screens from patient J.V. and failed to refer patient J.V. for appropriate detoxification.

57. Respondent was negligent in his care and treatment of patient J.V. when he failed to monitor J.V.'s available or accessible quantity of narcotics or sedatives.

58. Respondent was negligent in his care and treatment of patient J.V. as Respondent failed to obtain appropriate informed consents from patient J.V. for the various types and large

quantities of medications, either controlled or psychotropic, he prescribed to patient J.V.

59. Respondent was negligent in his care and treatment of patient J.V. when he made and maintained illegible and chaotic medical records and in other instances, failed to make and/or maintain any medical records at all.

60. Respondent was negligent in his care and treatment of patient J.V., taken singularly or collectively, when he violated J.V.'s confidentiality in the following circumstances:

(1) Respondent asked G.O. to deliver sedatives to patient J.V. and made arrangements for her to do so;

(2) After J.V. died, Respondent gossiped about the etiology of J.V.'s emotional problems with G.O.'s daughter on the phone;

(3) After J.V. died and Respondent received a fax from J.V.'s family accusing him of killing their child, Respondent discussed and agreed with G.O. on the telephone that she would calm the anger of J.V.'s parents.

Patient G.O.

61. The facts and circumstances alleged in paragraphs 39 to 46 are incorporated here as if fully set forth.

62. On or about November 9, 2010 through December 21, 2011, Respondent was repeatedly negligent in his care and treatment of patient G.O. when he:

(1) failed to maintain adequate and accurate records pertaining to the provision of services he provided to patient G.O.;

(2) prescribed patient G.O. controlled substances without a prior examination or medical indication.

Patient A.R.

63. The facts and circumstances alleged in paragraphs 48 to 50 are incorporated here as if fully set forth.

64. On or about May 23, 2014, Respondent was repeatedly negligent in his care and treatment of patient A.R. when he:

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(1) continued to treat patient A.R. while he was impaired after he had fallen asleep during the appointment;

(2) told patient A.R. that the session would stop until he first got a haircut and the session would resume after the haircut.

THIRD CAUSE FOR DISCIPLINE

(*Incompetence*)

65. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that he was incompetent in the care and treatment of two patients. The circumstances are as follows:

66. The facts and circumstances alleged in paragraphs 14 through 47 are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(*Inadequate Medical Record-Keeping*)

67. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to two patients, thereby committing unprofessional conduct. The circumstances are as follows:

68. The facts and circumstances alleged in paragraphs in paragraphs 14 through 47 are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(*Prescribing Without Medical Indication*)

69. Respondent is subject to disciplinary action under sections 2238 and 2242, subdivision (a), in that he prescribed dangerous drugs to two patients without an appropriate prior examination and a medical indication, thereby committing unprofessional conduct and violating state drug statutes. The circumstances are as follows:

70. The facts and circumstances alleged in paragraphs in paragraphs 14 through 47 are incorporated here as if fully set forth.

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SIXTH CAUSE FOR DISCIPLINE

(*Excessive Prescribing*)

71. Respondent is subject to disciplinary action under section 725 in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs as determined by the standard of the community of licensees. The circumstances are as follows:

72. The facts and circumstances alleged in paragraphs 14 through 47 are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(*Prescribing to an Addict*)

73. Respondent is subject to disciplinary action under section 2241 of the Code in that he prescribed 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. The circumstances are as follows:

74. The facts and circumstances alleged in paragraphs 14 through 47 are incorporated here as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(*General Unprofessional Conduct*)

75. Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct. The circumstances are as follows:

76. The facts and circumstances alleged in paragraphs 14 through 74 are incorporated here 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 A 22814, issued to Donald B. Horowitz, M.D.;

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

3. Ordering Donald B. Horowitz, 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: January 22, 2016

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

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