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9

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

12

13 In the Matter of the Accusation Against:

Case No. 800-2017-030714

14 **MARCO ANTONIO CHAVEZ, M.D.**
15 **1855 1st Avenue, Suite 200 B**
San Diego, CA 92101-2685

DEFAULT DECISION
AND ORDER

16 **Physician's and Surgeon's Certificate**
17 **No. A 115932,**

[Gov. Code, §11520]

17

Respondent.

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FINDINGS OF FACT

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21 1. On or about January 21, 2020, the executive director of the Medical Board of
22 California, Department of Consumer Affairs (Complainant), at the time Christine J. Lally serving
23 in her official capacity as Interim Executive Director, filed Accusation No. 800-2017-030714
against Respondent Marco Antonio Chavez, M.D. (Respondent) before the Board.¹

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25 2. On or about February 25, 2011, the Medical Board of California (Board) issued
26 Physician's and Surgeon's Certificate No. A 115932 to Respondent. The Physician's and
27 Surgeon's Certificate expired on June 30, 2018, and has not been renewed. A Certificate of

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¹ Effective June 15, 2020, William Prasifka was appointed Executive Director of the
Medical Board of California.

1 Licensure for Respondent, including his address of record with the Board, is included in the
2 accompanying *Evidence Packet in Support of Default Decision and Order (Evidence Packet)* as
3 Exhibit (Exh.) A, which is hereby incorporated by reference.

4 3. On or about January 21, 2020, an employee of the Board, served by certified mail a
5 copy of the Accusation No. 800-2017-030714, Statement to Respondent, Notice of Defense,
6 Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to
7 Respondent's address of record with the Board, which was and is 1855 1st Avenue, Suite 200 B,
8 San Diego, CA 92101-2685. On the same date, copies of the same documents were also served by
9 certified mail to an address in Texas believed to have been associated with Respondent (the Texas
10 Address). The Accusation, the related documents, and Declaration of Service are included in the
11 accompanying *Evidence Packet* as Exh. B, which is hereby incorporated by reference.

12 4. The copies of Accusation No. 800-2017-030714, and the accompanying documents
13 described in the Findings of Fact in paragraph 3, above, served on Respondent via certified mail
14 to Respondent's address of record with the Board and the Texas Address were each returned to
15 the Board by the U.S. Postal Service (USPS) respectively labelled "RETURN TO SENDER[,]
16 INSUFFICIENT ADDRESS[,] UNABLE TO FORWARD" and "RETURN TO SENDER[,]
17 UNCLAIMED[,] UNABLE TO FORWARD[,] RETURN TO SENDER[.]" The returned
18 envelopes and enclosed documents are included in the accompanying *Evidence Packet* as Exh. C.

19 5. On or about February 24, 2020, counsel for Complainant spoke via telephone with
20 Respondent's attorney of record in the case entitled *United States of America v. Marco Antonio*
21 *Chavez*, U.S. District Court, Southern District of California, Case No. 18CR2930L. Respondent's
22 attorney of record in that matter confirmed that his scope of representation of Respondent does
23 not include the instant accusation matter, but provided an email address he believed to be
24 associated with Respondent. (Declaration of Deputy Attorney General Giovanni F. Mejia [DAG
25 Mejia Decl.], ¶ 5, included in the accompanying *Evidence Packet* as Exh. D.)

26 6. On or about March 3, 2020, Complainant served copies of a Courtesy Notice of
27 Default on Respondent via first-class and certified mail to his address of record with the Board
28 and the Texas address. The Courtesy Notice of Default included, without limitation, a copy of

1 Accusation No. 800-2017-030714 and the Notice of Defense form, as described in the Findings of
2 Fact in paragraph 3, above. The Courtesy Notice of Default is included in the *Evidence Packet* as
3 Exh. E, which is hereby incorporated by reference.

4 7. On or about March 4, 2020, counsel for Complainant sent a true and correct copy of
5 the Courtesy Notice of Default to Respondent via email to the email address provided by
6 Respondent's attorney of record in the case entitled *United States of America v. Marco Antonio*
7 *Chavez*, U.S. District Court, Southern District of California, Case No. 18CR2930L. (Exh. D,
8 DAG Mejia Decl., ¶ 7.)

9 8. On or about March 19, 2020, counsel for Complainant received a telephone call from
10 a person identifying herself as a child of the primary resident of the Texas Address. The caller
11 stated Respondent does not reside at the Texas Address. (Exh. D, DAG Mejia Decl., ¶ 8.)

12 9. On or about March 16, 2020, the USPS returned the copy of the Courtesy Notice of
13 Default served on Respondent via first-class mail to Respondent's address of record with the
14 Board, with what appeared to be "no longer at this address[,] RTS" written on the envelope. On
15 or about March 20, 2020, the USPS returned the copy of the Courtesy Notice of Default served to
16 Respondent's address of record with the Board via certified mail, labelled "RETURN TO
17 SENDER[,] INSUFFICIENT ADDRESS[,] UNABLE TO FORWARD[.]" The returned
18 envelopes and enclosed documents for the copies of the Courtesy Notice of Default served on
19 Respondent at his address of record with the Board are included in the *Evidence Packet* as Exh. F.

20 10. On or about April 16, 2020, the USPS returned the copy of the Courtesy Notice of
21 Default served via certified mail to the Texas Address, labelled "RETURN TO SENDER[,] NOT
22 DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" The returned envelope and
23 enclosed documents for the copy of the Courtesy Notice of Default served to the Texas Address
24 via certified mail is included in the *Evidence Packet* as Exh. G.

25 11. Service of Accusation No. 800-2017-030714 was effective as a matter of law under
26 the provisions of Government Code section 11505, subdivision (c).

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1 12. Government Code section 11506 states, in pertinent part:

2 (c) The respondent shall be entitled to a hearing on the merits if the respondent
3 files a notice of defense, and the notice shall be deemed a specific denial of all parts
4 of the accusation not expressly admitted. Failure to file a notice of defense shall
5 constitute a waiver of respondent's right to a hearing, but the agency in its discretion
6 may nevertheless grant a hearing....

7 13. Respondent failed to file a Notice of Defense within 15 days after service upon him
8 of Accusation No. 800-2017-030714, and therefore waived his right to a hearing on the merits of
9 the Accusation. (Exh. D, DAG Mejia Decl., ¶¶ 1 through 4.)

10 14. To date, Respondent has failed to file *any* Notice of Defense to Accusation
11 No. 800-2017-030714. (Exh. D, DAG Mejia Decl., ¶¶ 1 through 4.)

12 15. Government Code section 11520 states, in pertinent part:

13 (a) If the respondent either fails to file a notice of defense or to appear at the
14 hearing, the agency may take action based upon the respondent's express admissions
15 or upon other evidence and affidavits may be used as evidence without any notice to
16 respondent.

17 16. Pursuant to its authority under Government Code section 11520, the Board finds
18 Respondent is in default. The Board will take action without further hearing and, based on
19 Respondent's express admissions by way of default and the evidence before it, contained in
20 Exhibits A through L in the accompanying *Evidence Packet*, finds that the charges and allegations
21 in Accusation No. 800-2017-030714, and each of them, separately and severally, are true and
22 correct.

23 17. Section 2227, subdivision (a) of the Business and Professions Code² states:

24 A licensee whose matter has been heard by an administrative law judge of the
25 Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or
26 whose default has been entered, and who is found guilty, or who has entered into a
27 stipulation for disciplinary action with the board, may, in accordance with the provisions of
28 this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year
upon order of the board.

² Unless noted otherwise, all code references hereinafter refer to the Business and Professions Code.

1 (3) Be placed on probation and be required to pay the costs of probation monitoring
2 upon order of the board.

3 (4) Be publicly reprimanded by the board. The public reprimand may include a
4 requirement that the licensee complete relevant educational courses approved by the board.

5 (5) Have any other action taken in relation to discipline as part of an order of
6 probation, as the board or an administrative law judge may deem proper.

7 18. Business and Professions Code section 118, subdivision (b) states:

8 (b) The suspension, expiration, or forfeiture by operation of law of a license
9 issued by a board in the department, or its suspension, forfeiture, or cancellation by
10 order of the board or by order of a court of law, or its surrender without the written
11 consent of the board, shall not, during any period in which it may be renewed,
12 restored, reissued, or reinstated, deprive the board of its authority to institute or
13 continue a disciplinary proceeding against the licensee upon any ground provided by
14 law or to enter an order suspending or revoking the license or otherwise taking
15 disciplinary action against the license on any such ground.

16 19. Section 2234 of the Code states, in pertinent part:

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

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

22 (b) Gross negligence.

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

27 (1) An initial negligent diagnosis followed by an act or omission medically
28 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....

20. Section 2239, subdivision (a) of the Code states:

(a) 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

1 more than one misdemeanor or any felony involving the use, consumption, or self
2 administration of any of the substances referred to in this section, or any combination
3 thereof, constitutes unprofessional conduct. The record of the conviction is
4 conclusive evidence of such unprofessional conduct.

4 21. Section 2280 of the Code states:

5 No licensee shall practice medicine while under the influence of any narcotic
6 drug or alcohol to such extent as to impair his or her ability to conduct the practice of
7 medicine with safety to the public and his or her patients. Violation of this section
8 constitutes unprofessional conduct and is a misdemeanor.

8 22. Section 725, subdivision (a) of the Code states:

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

13 23. Section 2242, subdivision (a) of the Code states, in pertinent part:

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

16 24. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
17 adequate and accurate records relating to the provision of services to their patients constitutes
18 unprofessional conduct."

19 25. Section 2021, subdivision (b) of the Code states:

20 Each licensee shall report to the board each and every change of address within
21 30 days after each change, giving both the old and new address. If an address reported
22 to the board at the time of application for licensure or subsequently is a post office
23 box, the applicant shall also provide the board with a street address. If another address
24 is the licensee's address of record, he or she may request that the second address not
25 be disclosed to the public.

24 26. Section 2236 of the Code states, in pertinent part:

25 (a) The conviction of any offense substantially related to the qualifications,
26 functions, or duties of a physician and surgeon constitutes unprofessional conduct
27 within the meaning of this chapter. The record of conviction shall be conclusive
28 evidence only of the fact that the conviction occurred.

...

1 (d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is
2 deemed to be a conviction within the meaning of this section and Section 2236.1. The
3 record of conviction shall be conclusive evidence of the fact that the conviction
4 occurred.

4 ***Impaired Practice and Interactions with Board Investigators***

5 27. On or about April 18, 2018, Investigator S.B. (Inv. S.B.) of the State of California,
6 Department of Consumer Affairs, Division of Investigation, Health Quality Investigation
7 Unit (HQIU) presented to Respondent's address of record with the Board, 1855 1st Avenue,
8 Suite 200 B, San Diego, CA 92101-2685 (the Office). (Declaration of HQIU Investigator S.B.
9 [Inv. S.B. Decl.], ¶¶ 4 and 6, a true and correct copy of which is included in the accompanying
10 *Evidence Packet* as Exh. H.)

11 28. At approximately 10:20 a.m., Respondent entered the waiting area where Inv. S.B.
12 was present. Respondent addressed two other individuals in the waiting area, explaining to them
13 that he would be with them in a few minutes. Inv. S.B. understood them to be patients of
14 Respondent awaiting their appointments. Respondent escorted Inv. S.B. back to Respondent's
15 office. (Exh. H, Inv. S.B. Decl., ¶ 7.)

16 29. Inv. S.B. observed Respondent walking very slowly and deliberately, and Respondent
17 appeared to almost lose his balance multiple times. As he talked with Respondent, Inv. S.B.
18 observed that Respondent's speech was slurred and very slow, and that Respondent appeared to
19 think about his words very carefully. Inv. S.B. recognized such conduct as objective symptoms of
20 alcohol intoxication based on Inv. S.B.'s training and experience as a sworn peace officer,
21 including hundreds of encounters with individuals impaired due to alcohol intoxication. (Exh. H,
22 Inv. S.B. Decl., ¶ 8.)

23 30. When Inv. S.B. and Respondent reached Respondent's office, Inv. S.B. observed that
24 the office was in disarray. There were paintings on the floor and leaning against Respondent's
25 desk and cabinets. Cleaning supplies were on the floor and there were numerous objects piled up
26 in the corner behind Respondent's desk. There were also papers on the floor under the wheels of
27 Respondent's chair. (Exh. H, Inv. S.B. Decl., ¶ 9.)

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1 31. In Respondent's office, Inv. S.B. asked Respondent when he had last consumed an
2 alcoholic beverage. Respondent stated that he had not had an alcoholic beverage since his parents
3 arrived from Texas in February 2018. Respondent stated that he has no problems with alcohol and
4 that he did not have any alcoholic beverages in his home or office. (Exh. H, Inv. S.B. Decl., ¶ 10.)

5 32. Inv. S.B. asked Respondent about the contents of various pieces of furniture in
6 Respondent's office, including a night stand behind Respondent's desk. Respondent opened the
7 top drawer of the night stand and Inv. S.B. observed a mostly empty 750 mL vodka bottle lying
8 on its side on top of some papers. Respondent stared at the bottle for approximately ten seconds
9 and then began mumbling. Inv. S.B. asked Respondent what type of alcohol was in the bottle and
10 Respondent replied, "vodka." (Exh. H, Inv. S.B. Decl., ¶ 11.)

11 33. Inv. S.B. informed Respondent that he believed Respondent was so intoxicated that
12 Respondent could not practice medicine safely. Respondent asked if he could notify his patients
13 in the waiting area. Inv. S.B. followed Respondent to the waiting area, whereupon he observed
14 Respondent inform two individuals Inv. S.B. understood to be patients that Respondent was sorry
15 but he needed to reschedule their appointments. During the walk to the waiting area, Respondent
16 continued to walk very slowly and deliberately, and also slightly lost his balance. (Exh. H, Inv.
17 S.B. Decl., ¶ 12.)

18 34. Inv. S.B. then observed Respondent appearing to call patients to cancel his
19 appointments for the rest of April 18, 2018, and the following two days (April 19, 2018, and
20 April 20, 2018). (Exh. H, Inv. S.B. Decl., ¶ 13.)

21 35. Additional investigators from HQIU arrived at Respondent's office and Respondent
22 stated that he had not consumed any alcoholic beverages. Inv. S.B. asked Respondent if he would
23 voluntarily provide a urine sample, which he agreed to do. (Exh. H, Inv. S.B. Decl., ¶ 14.)

24 36. After providing Inv. S.B. a urine sample, Respondent stated that his mother had been
25 giving him a Mexican home remedy to stop his drinking. Respondent stated that the remedy
26 consists of a glass of vodka mixed with fresh cloves. Respondent indicated that he had consumed
27 an approximately eight-ounce glass of the beverage at approximately 6:00 a.m., and another

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1 approximately eight-ounce glass of the beverage at approximately 7:00 a.m. (Exh. H, Inv. S.B.
2 Decl., ¶ 15.)

3 37. Respondent removed a tissue from one of his pants pockets, which contained some
4 small dark brown clumps of powder and what appeared to be small twigs. Respondent stated that
5 they were cloves and that he would chew on them during his work day in an attempt to not drink
6 the vodka. (Exh. H, Inv. S.B. Decl., ¶ 16.)

7 38. Inv. S.B. asked Respondent why his mother was concerned about his drinking and
8 making remedies to help Respondent stop. Respondent stated that a friend had invited him to an
9 Alcoholics Anonymous meeting, and that Respondent had gone to the meeting, but that it was not
10 for him. Respondent stated that he grew up in an era of binge drinking, that he binge drank before
11 his parents arrived from Texas, and that he has a problem with binge drinking. (Exh. H, Inv. S.B.
12 Decl., ¶ 17.)

13 39. Respondent also stated that he has been depressed but has not sought treatment. He
14 stated that he has been taking approximately 600 mg of gabapentin three times a day along with
15 Keppra. Respondent stated that he thinks he is being overdosed with gabapentin and had spoken
16 with his physician about it. (Exh. H, Inv. S.B. Decl., ¶ 18.)

17 40. Officer D.B. of the San Diego Police Department (Officer B.) arrived at the Office.
18 (Declaration of San Diego Police Department Officer D.B. [Officer B. Decl.], ¶ 2, a true and
19 correct copy of which is included in the accompanying *Evidence Packet* as Exh. I; Exh. H,
20 Inv. S.B. Decl., ¶ 19.)

21 41. Respondent voluntarily agreed to submit to a preliminary alcohol-screening (PAS)
22 test, which would measure his blood alcohol concentration (BAC). Officer B. administered a PAS
23 test on Respondent, which yielded a BAC of .216 percent. Approximately five minutes later,
24 Officer B. again administered a PAS test on Respondent, which yielded a BAC of .201 percent.
25 (Exh. I, Officer B. Decl., ¶¶ 3 through 5; Exh. H, Inv. S.B. Decl., ¶ 19.)

26 42. After the administration of the PAS tests, Respondent stated that he sees
27 approximately six or seven patients a day. He stated that he had seen two patients on
28 April 18, 2018 prior to meeting with Inv. S.B., and that he had issued a prescription to one of his

1 patients. Respondent further stated that he needs to get help with his drinking. (Exh. H, Inv. S.B.
2 Decl., ¶ 20.)

3 43. Based on observations of objective symptoms of intoxication, Respondent's
4 statements, and the PAS test results, the HQUI investigators determined that Respondent was a
5 danger to himself and to others if allowed to continue to practice medicine. Respondent stated
6 that he was closing his office for the rest of the week. Respondent appeared to close his office at
7 approximately 12:40 p.m., and two individuals Inv. S.B. understood to be Respondent's mother
8 and father arrived to pick up Respondent. (Exh. H, Inv. S.B. Decl., ¶ 21.)

9 44. The urine specimen provided by Respondent on or about April 18, 2018 later tested
10 positive for the presence of alcohol and temazepam.³ (Exh. H, Inv. S.B. Decl., ¶ 22.)

11 45. On or about April 30, 2018, Inv. S.B. and another HQUI investigator returned to the
12 Office. During this visit, Respondent refused to provide a urine specimen for the performance of a
13 urine drug screen. Respondent stated that his alcohol of choice is tequila, but that he was only
14 drinking vodka prior to Inv. S.B.'s visit on or about April 18, 2018 as a home remedy to stop
15 drinking. (Exh. H, Inv. S.B. Decl., ¶ 23.)

16 46. On or about May 7, 2018, an Ex Parte Interim Order of Suspension was issued by the
17 Office of Administrative Hearings (OAH), immediately suspending Respondent's Physician's
18 and Surgeon's Certificate No. A 115932, and prohibiting Respondent from practicing medicine in
19 the State of California. On or about May 22, 2018, an Interim Suspension Order was issued by
20 OAH leaving in full force and effect the prior ex parte order prohibiting Respondent from
21 practicing medicine in the State of California. Respondent has remained suspended from the
22 practice of medicine pending a final decision by the Board on an accusation. True and correct
23 copies of OAH's Ex Parte Interim Order of Suspension dated May 7, 2018 and Interim
24 Suspension Order dated May 22, 2018 are included in the accompanying *Evidence Packet* as
25 Exh. J, which is hereby incorporated by reference as if fully set forth herein. (See also Exh. D,
26 DAG Mejia Decl., ¶ 9.)

27 ³ Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code
28 section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code
section 4022.

1 47. Subsequent to the Office of Administrative Hearings' issuance of the Interim
2 Suspension Order issued on or about May 22, 2018, Inv. S.B. made numerous unsuccessful
3 attempts to contact or locate Respondent. (Exh. H, Inv. S.B. Decl., ¶¶ 26 through 31.)

4 48. Efforts made by Inv. S.B. to contact or locate Respondent in or after May 2018
5 included, but were not limited to, telephone calls to multiple telephone numbers Inv. S.B. knew or
6 believed to be associated with Respondent, and at least one email sent to an email address
7 Inv. S.B. knew or believed to be associated with Respondent. Inv. S.B. received no response from
8 Respondent to these communications. (Exh. H, Inv. S.B. Decl., ¶ 27.)

9 49. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included,
10 but were not limited to, a visit to the Office on or about September 19, 2018. A worker stated to
11 Inv. S.B. that Respondent had cleared out his office and left, and that the office space had been
12 rented to another tenant. No forwarding address for Respondent was available. (Exh. H, Inv. S.B.
13 Decl., ¶ 28.)

14 50. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included,
15 but were not limited to, a visit to a residential address known to Inv. S.B. to have been a prior
16 residence of Respondent. A construction worker at the residence stated to Inv. S.B. that
17 Respondent no longer resided there and that the apartment was being remodeled for another
18 tenant. (Exh. H, Inv. S.B. Decl., ¶ 29.)

19 51. On or about September 21, 2018, Inv. S.B. sent a written request to the United States
20 Postal Service (USPS) requesting a forwarding address for Respondent. Inv. S.B. did not
21 subsequently receive any forwarding address from the USPS. (Exh. H, Inv. S.B. Decl., ¶ 30.)

22 52. Respondent failed to timely notify the Board of his change of address and address of
23 record following his departure from the Office. (See Exh. H, Inv. S.B. Decl., ¶¶ 26 through 31,
24 42 through 44, 48 through 50, 59 through 61, 69 through 71, 75 through 77, 83 through 85,
25 91 and 92.)

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1 *Patient A*

2 53. In or around January 2017, “Patient A”⁴ presented to Respondent for psychiatric care
3 and treatment. During the appointment, Respondent gave Patient A one or more boxes of what
4 Patient A understood to be sample medication. (See Exh. H, Inv. S.B. Decl., ¶¶ 32 and 33.)

5 54. When Patient A returned home after the appointment, he and his spouse found a
6 small, empty vodka bottle inside a medication sample box that Patient A had received from
7 Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 34.)

8 *Patient B*

9 55. On multiple occasions in or around August 2017 to May 2018, “Patient B” presented
10 to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 37.)

11 56. During one or more psychiatric appointments with Respondent in or around
12 August 2017 to May 2018, Patient B observed Respondent exhibiting a sign or symptom of
13 alcohol intoxication including, but not limited to, the smell of alcohol, a flushed face, red, blood
14 shot or blurry eyes, impaired gait or stumbling, slurred speech, difficulty focusing,
15 unresponsiveness, or any combination thereof. (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 41.)

16 57. Subsequent to a psychiatric appointment with Respondent in or about May 2018,
17 Patient B was unable to contact Respondent or determine Respondent’s whereabouts.
18 (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 40.)

19 58. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail,
20 duly-authorized requests for Patient B’s medical records to Respondent addressed to the Office,
21 Respondent’s then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 42.)

22 59. On or about October 2, 2018, Inv. S.B. received the returned request for Patient B’s
23 medical records that had been sent via certified mail to Respondent, addressed to the Office. The
24 return label read, “RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO
25 FORWARD[.]” “NOT HERE” was hand-written on the return envelope. (Exh. H, Inv. S.B.
26 Decl., ¶ 43.)

27
28 ⁴ Patient names were withheld in Accusation No. 800-2017-030714 and are withheld in
the instant Default Decision & Order in the interests of preserving patient confidentiality.

Patient D

1
2 66. On multiple occasions in or around January 2013 to October 2017, “Patient D”
3 presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 51
4 through 54.)

5 67. During one or more medical appointments in or around January 2013 to
6 October 2017, Respondent disclosed personal or business information to Patient D without a valid
7 therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 12; Exh. H, Inv. S.B.
8 Decl., ¶¶ 51 and 52.)

9 68. On one or more occasions during the course of Respondent’s care and treatment of
10 Patient D in or around January 2013 to October 2017, Respondent requested that Patient D post a
11 positive online review of Respondent’s practice to promote his business. (See Exh. H, Inv. S.B.
12 Decl., ¶¶ 51 and 52.)

13 69. On multiple occasions during the course of Respondent’s care and treatment of
14 Patient D in or around January 2013 to October 2017, Respondent conducted a medication
15 monitoring appointment for Patient D of insufficient duration, on multiple occasions spending as
16 little as approximately two to five minutes with Patient D. (See Exh. K, Dr. Ornish Decl., ¶¶ 13
17 and 27; Exh. H, Inv. S.B. Decl., ¶¶ 51 and 52.)

18 70. On or about May 20, 2014, Patient D presented to Respondent. In his medical record
19 note for this appointment, Respondent failed to adequately establish or document the presence or
20 absence of medication side effects, or perform or document a mental status examination.
21 Respondent also failed to adequately document the medications prescribed to Patient D.
22 (See Exh. K, Dr. Ornish Decl., ¶¶ 14 and 15.)

23 71. Patient D presented to Respondent on or about July 28, 2015 and August 18, 2015. In
24 his medical record notes for these appointments, Respondent documented symptoms of major
25 depression including, but not limited to, a depressed mood, anxiety, poor sleep, irritability,
26 anhedonia, and decreased energy and appetite. However, during these appointments Respondent
27 failed to adequately take or document a history regarding the chronology and nature and extent of

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1 Patient D's symptoms, or a history regarding past response to treatment for any previous episodes
2 of major depression. (See Exh. K, Dr. Ornish Decl., ¶ 16.)

3 72. On or about July 28, 2015, Respondent prescribed approximately 30 mg per day of
4 Dexedrine⁶ to Patient D. Respondent failed to adequately document a basis for the prescribing of
5 this medication or medication amount. (See Exh. K, Dr. Ornish Decl., ¶ 17.)

6 73. In or about September 2015, Patient D presented to Respondent. In his medical record
7 note for this appointment, Respondent documented that the patient was doing great and that she
8 had no problems. Respondent failed to adequately obtain or document a history regarding the
9 disposition of Patient D's previously noted symptoms of major depressive disorder with anxiety
10 and panic attacks. (See Exh. K, Dr. Ornish Decl., ¶ 18.)

11 74. On or about June 27, 2016, Patient D presented to Respondent. In his medical record
12 note for this appointment, Respondent documented that Patient D had four to six symptoms of
13 depression, as well as anxiety and panic attacks. However, Respondent failed to adequately take
14 or document a history of the nature and extent of any such symptoms of depression. (See Exh. K,
15 Dr. Ornish Decl., ¶ 19.)

16 75. In his medical record note for the appointment with Patient D on or about June 27,
17 2016, Respondent documented Xanax⁷ was one of Patient D's current medications but
18 documented issuing a refill for another benzodiazepine, Klonopin.⁸ (Exh. K, Dr. Ornish
19 Decl., ¶ 20.)

20 76. On or about October 18, 2016, Patient D presented to Respondent. In his medical
21 record note for this appointment, Respondent documented that Patient D was doing well, had no
22 problems and was just there for refills. Respondent failed to adequately obtain or document an

23 ⁶ Dexedrine, a brand name for dextroamphetamine, is a Schedule II controlled substance
24 pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug
pursuant to Business and Professions Code section 4022.

25 ⁷ Xanax, a brand name for alprazolam, is a Schedule IV controlled substance pursuant to
26 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
Business and Professions Code section 4022. It is an anti-anxiety medication in the
benzodiazepine family.

27 ⁸ Klonopin, a brand name for clonazepam, is a Schedule IV controlled substance pursuant
28 to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
Business and Professions Code section 4022. It is an anti-anxiety medication in the
benzodiazepine family.

1 interval history including, but not limited to, Patient D's response to treatment, or whether or how
2 the previously reported symptoms of depression had resolved. (See Exh. K, Dr. Ornish
3 Decl., ¶ 21.)

4 77. On at least one occasion in or around 2017, Respondent issued concurrent
5 prescriptions for at least two benzodiazepines, Xanax and Klonopin, to Patient D. (Exh. K,
6 Dr. Ornish Decl., ¶ 23.)

7 78. On or about September 6, 2017, Patient D presented to Respondent. In his medical
8 record for this appointment, Respondent documented that he informed Patient D that he was
9 terminating her as a patient. (Exh. K, Dr. Ornish Decl., ¶ 24.)

10 79. By letter dated October 2, 2017, Respondent notified Patient D that he had terminated
11 her as a patient effective September 22, 2017. (Exh. K, Dr. Ornish Decl., ¶ 25.)

12 80. In terminating his medical care and treatment of Patient D, Respondent failed to
13 provide Patient D prompt written notice of any availability of emergency treatment or access to
14 services for a reasonable amount of time during which Patient D could arrange for care with a
15 another healthcare provider. (See Exh. K, Dr. Ornish Decl., ¶ 26.)

16 81. Throughout the course of Respondent's care and treatment of Patient D in or around
17 January 2013 to October 2017, Respondent failed to properly treat Patient D's symptoms of major
18 depression including, but not limited to, failing to adequately offer or administer psychotherapy
19 or antidepressant treatment. (Exh. K, Dr. Ornish Decl., ¶ 22.)

20 *Patient E*

21 82. On multiple occasions in or around September 2013 to 2018, "Patient E" presented to
22 Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 55 through 57.)

23 83. In or around 2017 or 2018, Respondent recommended to Patient E that, based at least
24 in part on her medical condition, she take time off from work and apply for public benefits. (See
25 Exh. H, Inv. S.B. Decl., ¶ 57.)

26 84. Patient E subsequently applied for public benefits and, as a part of the application
27 process, requested on multiple occasions that Respondent provide a copy of her medical records.
28 (See Exh. H, Inv. S.B. Decl., ¶ 57.)

1 85. Respondent failed to provide a copy of Patient E's medical records to Patient E or the
2 public benefits program Patient E had applied to. (See Exh. H, Inv. S.B. Decl., ¶ 58.)

3 86. Following the issuance of the Interim Order of Suspension suspending Respondent's
4 Physician's and Surgeon's Certificate No. A 115932, effective May 7, 2018, Patient E was unable
5 to successfully contact Respondent or obtain a copy of medical records that had been maintained
6 by Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 55.)

7 87. In or after May 2018, Respondent failed to take adequate steps to attempt to arrange
8 for coverage or transition to a new treating psychiatrist after Respondent was unable to care for
9 Patient E. (See Exh. K, Dr. Ornish Decl., ¶ 33.)

10 88. On or about January 31, 2019, Inv. S.B. sent, via first-class and certified mail, duly-
11 authorized requests for Patient E's medical records to Respondent addressed to the Office,
12 Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 59.)

13 89. On or about February 12, 2019, Inv. S.B. received the returned request for Patient E's
14 medical records that had been sent via first-class mail to Respondent, addressed to the Office.
15 The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE
16 TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 60.)

17 90. On or about February 19, 2019, Inv. S.B. received the returned request for Patient E's
18 medical records that had been sent via certified mail to Respondent, addressed to the Office. The
19 return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,]
20 UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 61.)

21 *Patient F*

22 91. On multiple occasions in or around June 2015 to October 2017, "Patient F" presented
23 to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 62 through 65.)

24 92. On or about June 24, 2015, Respondent conducted an initial intake appointment with
25 Patient F. During this initial intake appointment, Respondent failed to take or document an
26 adequate psychiatric medical history for Patient F including, but not limited to, failing to
27 adequately detail when Patient F commenced taking certain psychotropic medications, the history
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1 and scope of Patient F's post-traumatic stress disorder (PTSD) symptoms, and Patient F's past
2 response to psychotropic medications. (See Exh. K, Dr. Ornish Decl., ¶ 34.)

3 93. In his medical record note for the initial intake appointment on or about June 24,
4 2015, Respondent documented that Patient F had a prior suicide attempt, but failed to document
5 the nature of the suicide attempt, the precipitant for it, or when it occurred. (See Exh. K,
6 Dr. Ornish Decl., ¶ 35.)

7 94. In his medical record note for the initial intake appointment on or about June 24,
8 2015, Respondent documented that Patient F had a prior psychiatric hospitalization, but failed to
9 adequately document details regarding this hospitalization including, but not limited to, where,
10 when, why and for how long she was hospitalized, whether the hospitalization had any
11 connection to the documented prior suicide attempt, or the nature of the treatment received during
12 the hospitalization. (See Exh. K, Dr. Ornish Decl., ¶ 36.)

13 95. In his medical record note for the initial intake appointment on or about June 24,
14 2015, Respondent documented a statement to the effect that all of Patient F's psychotropic
15 medications were increased, without adequate further details including, but not limited to, the
16 new medication dosages, quantities or number of refills. (See Exh. K, Dr. Ornish Decl., ¶ 37.)

17 96. On or about August 5, 2015, Patient F presented to Respondent. In his medical record
18 for this appointment, Respondent documented panic attacks as a target symptom for Patient F for
19 the first time. However, Respondent failed to adequately document details regarding the history
20 of any such panic attacks including, but not limited to, the nature and extent of her purported
21 panic attacks or response to treatment. (See Exh. K, Dr. Ornish Decl., ¶ 38.)

22 97. On or about November 9, 2015, Patient F presented to Respondent. In his medical
23 record for this appointment, Respondent documented that Patient F had been in a motor vehicle
24 accident and that she had suffered a few scratches. However, Respondent failed to adequately
25 inquire about or document details regarding the accident including, but not limited to, whether
26 Patient F was the driver, sedation from Patient F's medications may have been a contributing
27 factor, or Patient F had combined her medications with alcohol. (See Exh. K, Dr. Ornish
28 Decl., ¶ 39.)

1 98. In his medical record for the appointment with Patient F on or about
2 November 9, 2015, Respondent documented that he discontinued a Xanax prescription for
3 Patient F and commenced a Klonopin prescription. However, Respondent failed to document a
4 rationale for this change, the quantity of Klonopin dispensed or prescribed, or the number of
5 refills provided. (See Exh. K, Dr. Ornish Decl., ¶ 40.)

6 99. On or about April 7, 2016, Patient F presented to Respondent. Respondent failed to
7 adequately perform or document a mental status examination for this appointment. (See Exh. K,
8 Dr. Ornish Decl., ¶ 41.)

9 100. On or about June 9, 2016, Patient F presented to Respondent. In his medical record
10 for this appointment, Respondent documented major depressive disorder (MDD) and generalized
11 anxiety disorder (GAD) in addition to his prior working diagnosis of PTSD. However,
12 Respondent failed to adequately document a rationale for adding MDD and GAD as working
13 diagnoses. (Exh. K, Dr. Ornish Decl., ¶ 42.)

14 101. During an approximately two-month period in or around February 2, 2017 to
15 March 31, 2017, the California Controlled Substance Utilization Review and Evaluation System
16 (CURES) database lists the following prescriptions as having been issued by Respondent and
17 filled by Patient F:

	Fill Date	Drug Name	Strength	Quantity	Days Supply
18					
19	2/2/2017	Clonazepam	1 MG	60	15
20	2/2/2017	Zolpidem Tartrate ⁹	10 MG	30	30
21	2/9/2017	Clonazepam	1 MG	60	30
22	2/9/2017	Zolpidem Tartrate	10 MG	30	30
23	3/2/2017	Zolpidem Tartrate	10 MG	30	30
24	3/2/2017	Clonazepam	1 MG	60	15
25	3/13/2017	Clonazepam	1 MG	60	30
26	3/13/2017	Zolpidem Tartrate	10 MG	30	30

27 ⁹ Zolpidem, also known as Ambien, Ivadal, Stilnoct or Tilnox, is a Schedule IV controlled
28 substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous
drug pursuant to Business and Professions Code section 4022.

	Fill Date	Drug Name	Strength	Quantity	Days Supply
1					
2	3/31/2017	Clonazepam	1 MG	60	30
3	3/31/2017	Zolpidem Tartrate	10 MG	30	30

4 (Exh. H, Inv. S.B. Decl., ¶ 66.)

5 102. During the approximately two-month period in or around February 2, 2017 to
6 March 31, 2017, the clonazepam and zolpidem tartrate prescriptions filled to Patient F, per the
7 CURES database, correspond to prescription dosages that are inconsistent with the dosages
8 documented in Respondent’s medical records for Patient F in or around the same period. (Exh. K,
9 Dr. Ornish Decl., ¶ 43.)

10 103. On or about March 13, 2017, Respondent’s office was contacted by a pharmacy
11 regarding a request to fill a prescription issued by Respondent for sixty 1 mg tablets of
12 clonazepam and thirty 10 mg tablets of zolpidem tartrate. Respondent’s office approved the
13 request, but Respondent’s medical records for Patient F contain no adequate explanation why the
14 filling of these prescriptions was approved. (See Exh. K, Dr. Ornish Decl., ¶ 44.)

15 104. Throughout the course of Respondent’s care and treatment of Patient F in or around
16 June 2016 to October 2017, Respondent failed to adequately review, or document adequate
17 review of, the CURES database for controlled substance prescriptions issued to and filled by
18 Patient F. (See Exh. K, Dr. Ornish Decl., ¶ 45.)

19 105. On one or more occasions in or around June 2015 to October 2017, Respondent
20 conducted a medication monitoring appointment for Patient F of insufficient duration, on at least
21 one occasion spending as little as approximately two minutes with Patient F. (See Exh. K,
22 Dr. Ornish Decl., ¶¶ 46 and 48.)

23 106. On one or more occasions in or around June 2015 to October 2017, Respondent
24 disclosed personal information regarding Respondent to Patient F during a medical appointment
25 without a valid therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 47.)

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Patient G

107. On multiple occasions in or around September 2015 to May 2018, “Patient G” presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 through 72.)

108. On or about May 31, 2018, Patient G presented to the Office for a scheduled appointment with Respondent. Upon or shortly after arrival, a purported receptionist for another physician stated to Patient G that Respondent and his staff had left the location weeks prior. The receptionist further stated that Respondent had not left a forwarding address and that Patient G would not be able to obtain a copy of her medical records. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 and 68.)

109. Respondent failed to take adequate steps to notify Patient G regarding the cessation of his practice at the Office. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 and 68.)

110. On or about January 10, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient G’s medical records to Respondent addressed to the Office, Respondent’s then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 69.)

111. On or about January 22, 2019, Inv. S.B. received the returned request for Patient G’s medical records that had been sent, via first-class mail, to Respondent addressed to the Office. The return label read, “RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]” (Exh. H, Inv. S.B. Decl., ¶ 70.)

112. On or about January 28, 2019, Inv. S.B. received the returned, undelivered request for Patient G’s medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, “RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]” (Exh. H, Inv. S.B. Decl., ¶ 71.)

Patient H

113. On multiple occasions in or around September 2016 to April 2018, Patient H presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 73 through 78.)

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1 114. In or around April 2018, Patient H presented to the Office for a scheduled
2 appointment with Respondent. When Patient H arrived, he was told by a worker that Respondent
3 had to cancel Patient H's appointment because of an emergency. Patient H received no
4 information regarding a covering physician or referral to another treatment provider. (See Exh. H,
5 Inv. S.B. Decl., ¶ 73.)

6 115. Later that day and over the following days, Patient H made multiple attempts to
7 contact Respondent by telephone, text message and email to discuss topics including, without
8 limitation, rescheduling a medical appointment or difficulties that Patient H was experiencing
9 tolerating one or more recently prescribed medications. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

10 116. On or about April 25, 2018, Patient H received an email from Respondent in which
11 Respondent stated that he had suffered a seizure and that Respondent was doing his best to get
12 back to his patients. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

13 117. Other than the email received on or about April 25, 2018, Patient H did not receive a
14 response to his multiple communication attempts after the cancelled appointment in or around
15 April 2018. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

16 118. Patient H received no written notification from Respondent regarding termination of
17 care. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

18 119. Following the cancelled appointment with Respondent in or around April 2018,
19 Patient H was unable to access any medical records maintained by Respondent. (See Exh. H,
20 Inv. S.B. Decl., ¶ 73.)

21 120. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail,
22 duly-authorized requests for Patient H's medical records to Respondent addressed to the Office,
23 Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 75.)

24 121. On or about October 2, 2018, Inv. S.B. received the returned request for Patient H's
25 medical records that had been sent via certified mail to Respondent, addressed to the Office. The
26 return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO
27 FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 76.)

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1 122. On or about December 11, 2018, Inv. S.B. received the returned request for
2 Patient H's medical records that had been sent via first-class mail to Respondent, addressed to the
3 Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
4 ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 77.)

5 *Patient J*

6 123. On multiple occasions commencing in or around July 2017, "Patient J" presented to
7 Respondent for medical care and treatment. (Exh. H, Inv. S.B. Decl., ¶¶ 79 through 86.)

8 124. On one or more occasions during a medical appointment in or after July 2017,
9 Respondent disclosed personal or business-related information to Patient J without a valid
10 therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 56 and 59.)

11 125. In or around June 2018, Patient J attempted to contact Respondent at multiple
12 telephone numbers or email addresses that Patient J had known or reason to believe to be
13 associated with Respondent. Patient J received no response from Respondent. (See Exh. H,
14 Inv. S.B. Decl., ¶¶ 79 through 82.)

15 126. In or around June 2018, Patient J mailed a letter to Respondent requesting a copy of
16 his medical records. Patient J received no response and was unable to obtain a copy of his
17 medical records from Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 79.)

18 127. On or about January 15, 2019, Inv. S.B. sent, via first-class and certified mail, duly-
19 authorized requests for Patient J's medical records to Respondent addressed to the Office,
20 Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 83.)

21 128. On or about January 29, 2019, Inv. S.B. received the returned request for Patient J's
22 medical records that had been sent via first-class mail to Respondent, addressed to the Office.
23 The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,]
24 UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 84.)

25 129. On or about February 5, 2019, Inv. S.B. received the returned, undelivered request for
26 Patient J's medical records that had been sent via certified mail to Respondent, addressed to the
27 Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
28 ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 85.)

Patient K

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2 130. On multiple occasions in or around March 2017 to 2018, "Patient K" received
3 medical care and treatment from Respondent. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 through 93.)

4 131. On one or more occasions in the course of Respondent's care and treatment of
5 Patient K in or around March 2017 to 2018, Respondent cried or disclosed personal issues to
6 Patient K during a medical appointment without a valid therapeutic reason for doing so. (See
7 Exh. K, Dr. Ornish Decl., ¶¶ 60 and 61.)

8 132. On or about May 8, 2018, Patient K presented to Respondent for a medical
9 appointment at the Office. Upon or shortly after arrival, Patient K observed a sign on a door
10 stating, among other things, that Respondent would be out of the office and that all appointments
11 were cancelled until further notice. The sign stated, "If you need refills please contact your
12 Primary Care Doctor." The sign failed to include any forwarding or other contact information for
13 Respondent. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 and 88.)

14 133. Patient K walked through the waiting area back toward Respondent's office.
15 Patient K found Respondent in his office and observed him crying and packing his things.
16 Respondent told Patient K that a staff person had stolen money from him and that the staff person
17 had further gone to a governmental entity and complained that Respondent was seeing patients
18 under the influence of alcohol. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 through 89.)

19 134. Subsequent to the May 2018 encounter with Respondent, Patient K found another
20 healthcare provider. However, as late as December 2018, neither Patient K nor the subsequent
21 healthcare provider were able to obtain a copy of Respondent's medical record for Patient K. (See
22 Exh. H, Inv. S.B. Decl., ¶¶ 87 through 90.)

23 135. On or about December 17, 2018, Inv. S.B. sent, via first-class and certified mail,
24 duly-authorized requests for Patient K's medical records to Respondent addressed to the Office,
25 Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 91.)

26 136. On or about December 31, 2018, Inv. S.B. received the returned requests for
27 Patient K's medical records that had been sent, via first-class and certified mail, to Respondent

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1 addressed to the Office. The return labels read, "RETURN TO SENDER[,] ATTEMPTED –
2 NOT KNOWN[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 92.)

3 ***Guilty Plea to Health Care Fraud***

4 137. On or about August 20, 2019, Respondent pleaded guilty to a felony violation of
5 18 U.S.C., § 1347 (Health Care Fraud) in the case entitled *United States of America v. Marco*
6 *Antonio Chavez*, U.S. District Court, Southern District of California, Case No. 18CR2930L. True
7 and correct copies of the Indictment, Plea Agreement, Findings and Recommendation of the
8 Magistrate Judge Upon a Plea of Guilty, and Order adopting the Findings and Recommendation
9 of the Magistrate Judge Upon a plea of Guilty in *United States of America v. Marco Antonio*
10 *Chavez* are included in the *Evidence Packet* as Exh. L, which is hereby incorporated by reference.
11 (See also Exh. D, DAG Mejia Decl., ¶ 10.)

12 **FIRST CAUSE FOR DISCIPLINE**

13 **(Use of Drugs or Alcoholic Beverages in a Manner, or to an Extent, as to be Dangerous to**
14 **Himself, to Another Person, or to the Public)**

15 138. Respondent has subjected his Physician's and Surgeon's Certificate No. A 115932 to
16 disciplinary action under sections 2227 and 2234, as defined by section 2239, subdivision (a), of
17 the Code, in that he used or prescribed, or administered to himself, drugs or alcoholic beverages
18 to the extent, or in such manner, as to be dangerous or injurious to him, to another person, or to
19 the public as more particularly described in the Findings of Fact in paragraphs 27 through 56,
20 above, which are hereby incorporated by reference as if fully set forth herein.

21 **SECOND CAUSE FOR DISCIPLINE**

22 **(Practice of Medicine While Under the Influence of Any Narcotic Drug or Alcohol)**

23 139. Respondent has further subjected his Physician's and Surgeon's Certificate
24 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2280, of
25 the Code, in that he practiced medicine while under the influence of any narcotic drug or alcohol
26 to such an extent as to impair his or her ability to conduct the practice of medicine with safety to
27 the public and his or her patients, as more particularly described in the Findings of Fact in

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1 paragraphs 27 through 56, above, which are hereby incorporated by reference as if fully set forth
2 herein.

3 **THIRD CAUSE FOR DISCIPLINE**

4 **(Gross Negligence)**

5 140. Respondent has further subjected his Physician's and Surgeon's Certificate
6 No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in
7 that he committed gross negligence in his care and treatment of one or more patients. The
8 circumstances are as follows:

9 141. The Findings of Fact in paragraphs 47 through 52, and 61 through 136, above, are
10 hereby incorporated by reference as if fully set forth herein.

11 142. Respondent committed gross negligence in his care and treatment of Patient C
12 including, but not limited to, failing to take adequate steps to provide Patient C or duly authorized
13 third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 11.)

14 143. Respondent committed gross negligence in his care and treatment of Patient D
15 including, but not limited to:

16 (a) Failing to maintain appropriate professional boundaries with Patient D.

17 (b) Conducting one or more medication management appointments of inadequate
18 duration with Patient D.

19 (c) Failing to adequately document details regarding one or more prescriptions
20 issued to Patient D including, but not limited to, the prescription name, quantity, dosage,
21 clinical indication, or any combination thereof.

22 (d) Failing to document or maintain an adequate psychiatric history and record for
23 Patient D.

24 (e) Failing to properly treat Patient D's symptoms of major depression.

25 (f) Concurrently prescribing more than one benzodiazepine to Patient D.

26 (See Exh. K, Dr. Ornish Decl., ¶ 27.)

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1 144. Respondent committed gross negligence in his care and treatment of Patient E
2 including, but not limited to, failing to adequately:

3 (a) Provide a copy of Patient E's medical records to Patient E or the public benefits
4 program to which she had applied.

5 (b) Take steps to provide Patient E or duly authorized third parties access to
6 medical records.

7 (c) Take steps to attempt to arrange coverage or a transition of care to another
8 treating psychiatrist once Respondent was unable to provide care to Patient E.

9 (See Exh. K, Dr. Ornish Decl., ¶ 33.)

10 145. Respondent committed gross negligence in his care and treatment of Patient F
11 including, but not limited to:

12 (a) Conducting one or more medication monitoring appointments of inadequate
13 duration with Patient F.

14 (b) Failing to maintain appropriate professional boundaries with Patient F.

15 (c) Failing to adequately obtain or document details regarding Patient F's history of
16 a suicide attempt and psychiatric hospitalization.

17 (d) Failing to adequately obtain or document details regarding Patient F's reported
18 panic attacks.

19 (e) Failing to adequately document details regarding prescriptions issued to
20 Patient F.

21 (f) Prescribing controlled substances to Patient F without establishing or
22 documenting adequate medical indication.

23 (See Exh. K, Dr. Ornish Decl., ¶ 48.)

24 146. Respondent committed gross negligence in his care and treatment of Patient G
25 including, but not limited to, failing to take adequate steps to provide Patient G or duly authorized
26 third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 52.)

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1 147. Respondent committed gross negligence in his care and treatment of Patient H
2 including, but not limited to, failing to take adequate steps to provide Patient H or duly authorized
3 third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 55.)

4 148. Respondent committed gross negligence in his care and treatment of Patient J
5 including, but not limited to, failing to adequately:

6 (a) Maintain professional boundaries with Patient J.

7 (b) Take steps to provide Patient J or duly authorized third parties access to
8 medical records.

9 (See Exh. K, Dr. Ornish Decl., ¶ 59.)

10 149. Respondent committed gross negligence in his care and treatment of Patient K
11 including, but not limited to, failing to adequately:

12 (a) Take steps to provide Patient K or duly authorized third parties access to
13 medical records.

14 (b) Maintain professional boundaries with Patient K.

15 (See Exh. K, Dr. Ornish Decl., ¶ 64.)

16 **FOURTH CAUSE FOR DISCIPLINE**

17 **(Repeated Negligent Acts)**

18 150. Respondent has further subjected his Physician's and Surgeon's Certificate
19 No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (c) of the Code in
20 that he committed repeated negligent acts in his care and treatment of one or more patients. The
21 circumstances are as follows:

22 151. The Findings of Fact in paragraphs 47 through 52, 61 through 136, and 140
23 through 149, above, are hereby incorporated by reference as if fully set forth herein.

24 152. Respondent committed additional negligent acts in his care and treatment of Patient D
25 including, but not limited to, failing to provide adequate notice to Patient D regarding termination
26 of care. (See Exh. K, Dr. Ornish Decl., ¶ 28.)

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1 153. Respondent committed additional negligent acts in his care and treatment of Patient F
2 including, but not limited to, failing to adequately:

3 (a) Obtain or document a general psychiatric history during Patient F's initial
4 intake appointment on or about June 24, 2015.

5 (b) Obtain or document details regarding Patient F's reported motor vehicle
6 accident in or around November 2015.

7 (c) Document details regarding the change of Patient F's benzodiazepine
8 prescription from Xanax to Klonopin in or about November 2015.

9 (d) Perform or document a mental status examination during Patient F's
10 appointment on or about April 7, 2016.

11 (e) Document a rationale for changing the working diagnoses for Patient F on or
12 about June 9, 2016.

13 (See Exh. K, Dr. Ornish Decl., ¶ 49.)

14 **FIFTH CAUSE FOR DISCIPLINE**

15 **(Excessive Prescribing)**

16 154. Respondent has further subjected his Physician's and Surgeon's Certificate
17 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 725,
18 subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing,
19 furnishing, dispensing, or administering of drugs or treatment as more particularly described in
20 the Findings of Fact in paragraphs 66 to 81, 91 to 106, 143, and 145, above, which are hereby
21 incorporated by reference as if fully set forth herein. (See Exh. K, Dr. Ornish Decl., ¶¶ 29
22 and 50.)

23 **SIXTH CAUSE FOR DISCIPLINE**

24 **(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior
25 Examination and a Medical Indication)**

26 155. Respondent has further subjected his Physician's and Surgeon's Certificate
27 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2242,
28 subdivision (a), of the Code in that he prescribed a dangerous drug without an appropriate prior

1 examination and a medical indication as more particularly described in the Findings of Fact in
2 paragraphs 66 to 81, 91 to 106, 143, and 145, which are hereby incorporated by reference and
3 realleged as if fully set forth herein.

4 **SEVENTH CAUSE FOR DISCIPLINE**

5 **(Failure to Maintain Adequate and Accurate Records)**

6 156. Respondent has further subjected his Physician's and Surgeon's Certificate
7 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of
8 the Code in that he failed to maintain adequate and accurate records relating to the provision of
9 services to his patients as more particularly described in the Findings of Fact in paragraphs 55
10 through 136 and 140 through 153, above, which are hereby incorporated by reference as if fully
11 set forth herein.

12 **EIGHTH CAUSE FOR DISCIPLINE**

13 **(Failure to Timely Report a Change of Address to the Board)**

14 157. Respondent has further subjected his Physician's and Surgeon's Certificate
15 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
16 subdivision (a), of the Code in that he violated section 2021, subdivision (b) of the Code by
17 failing to notify the Board of one or more changes of address within 30 days as more particularly
18 described in the Findings of Fact in paragraphs 27 through 52, and 55 to 136, above, which are
19 hereby incorporated by reference as if fully set forth herein.

20 **NINTH CAUSE FOR DISCIPLINE**

21 **(Conviction Related to the Qualifications, Functions or Duties of a Licensee)**

22 158. Respondent has further subjected his Physician's and Surgeon's Certificate
23 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of
24 the Code in that he was convicted, by his plea of guilty, to an offense substantially related to the
25 qualifications, functions or duties of a licensee as more particularly described in the Findings of
26 Fact in paragraph 137, above, which is hereby incorporated by reference as if fully set forth
27 herein.

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1 **TENTH CAUSE FOR DISCIPLINE**

2 **(Violating the Medical Practice Act)**

3 159. Respondent further has subjected his Physician's and Surgeon's Certificate
4 No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (a) in that he
5 violated or attempted to violate, directly or indirectly, one or more provisions of the Medical
6 Practice Act, as more particularly described in the Findings of Fact in paragraphs 27 through 158,
7 above, which are hereby incorporated by reference as if fully set forth herein.

8 **DETERMINATION OF ISSUES**

9 1. Pursuant to Government Code section 11520, the Board hereby takes action based
10 upon Respondent's express admissions or upon other evidence contained in the accompanying
11 *Evidence Packet* filed herewith.

12 2. Pursuant to its authority under Government Code section 11520, and based on the
13 evidence before it, the Board hereby finds that the charges and allegations in Accusation
14 No. 800-2017-030714, and the Findings of Fact in paragraphs 1 through 159, above, and each of
15 them, severally and separately, are true and correct.

16 3. Pursuant to its authority under section 2227 of the Code and section 11520 of the
17 Government Code, and based on the evidence before it, the Findings of Fact in paragraphs 1
18 through 159, above, and the Determinations of Issues 1 and 2, above, the Board hereby finds that
19 Respondent Marco Antonio Chavez, M.D. has subjected his Physician's and Surgeon's
20 Certificate No. A 115932 to disciplinary action in that:

21 (a) Respondent used drugs or alcoholic beverages in a manner, or to an extent, as
22 to be dangerous to himself, to another person, or to the public, which constitutes grounds
23 for Board disciplinary action pursuant to sections 2234 and 2239, subdivision (a) of the
24 Code;

25 (b) Respondent engaged in the practice of medicine while under the influence of
26 any narcotic drug or alcohol, which constitutes grounds for Board disciplinary action
27 pursuant to sections 2234 and 2280 of the Code;

28 ///

1 (c) Respondent committed gross negligence in the course of his care and treatment
2 of one or more patients, which constitutes grounds for Board disciplinary action pursuant to
3 section 2234, subdivision (b) of the Code;

4 (d) Respondent committed repeated negligent acts in the course of his care and
5 treatment of one or more patients, which constitutes grounds for Board disciplinary action
6 pursuant to section 2234, subdivision (c) of the Code;

7 (e) Respondent committed repeated acts of clearly excessive prescribing,
8 furnishing, dispensing, or administering of drugs or treatment, which constitutes grounds
9 for Board disciplinary action pursuant to sections 2234 and 725, subdivision (a) of the
10 Code;

11 (f) Respondent prescribed a dangerous drug without an appropriate prior
12 examination and a medical indication on one or more occasions, which constitutes grounds
13 for Board disciplinary action pursuant to sections 2234 and 2242, subdivision (a) of the
14 Code;

15 (g) Respondent failed to maintain adequate and accurate records relating to the
16 provision of services to his patients, which constitutes grounds for Board disciplinary action
17 pursuant to sections 2234 and 2266 of the Code;

18 (h) Respondent failed to notify the Board of one or more changes of address
19 within 30 days, which constitutes grounds for Board disciplinary action pursuant to
20 sections 2234, subdivision (a) and 2021, subdivision (b) of the Code;

21 (i) Respondent was convicted of an offense substantially related to the
22 qualifications, functions or duties of a licensee, which constitutes grounds for Board
23 disciplinary action pursuant to sections 2234 and 2236 of the Code; and

24 (j) Respondent violated or attempted to violate, directly or indirectly, one or more
25 provisions of the Medical Practice Act, which constitutes grounds for Board disciplinary
26 action pursuant to section 2234, subdivision (a) of the Code.

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ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. A 115932, heretofore issued to Respondent Marco Antonio Chavez, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective at 5:00 p.m. on **JUL 23 2020**.

It is so ORDERED **JUN 23 2020**



WILLIAM PRASIFKA
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

13
14 In the Matter of the Accusation Against:

Case No. 800-2017-030714

15 **Marco Antonio Chavez, M.D.**
1855 1st Avenue, Suite 200 B
16 San Diego, CA 92101-2685

ACCUSATION

17 **Physician's and Surgeon's Certificate**
No. A 115932,

18 Respondent.
19

20 **PARTIES**

21 1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity
22 as the Interim Executive Director of the Medical Board of California, Department of Consumer
23 Affairs (Board).

24 2. On or about February 25, 2011, the Medical Board issued Physician's and Surgeon's
25 Certificate No. A 115932 to Marco Antonio Chavez, M.D. (Respondent). The Physician's and
26 Surgeon's Certificate expired on June 30, 2018, and has not been renewed.

27 3. On or about May 7, 2018, an Ex Parte Interim Order of Suspension was issued by the
28 Office of Administrative Hearings, immediately suspending Respondent's Physician's and

1 Surgeon's Certificate No. A 115932, and prohibiting respondent from practicing medicine in the
2 State of California. On or about May 22, 2018, an Interim Suspension Order was issued by the
3 Office of Administrative Hearings leaving in full force and effect the prior ex parte order
4 prohibiting Respondent from practicing medicine in the State of California. Respondent remains
5 suspended from the practice of medicine pending the issuance of a final decision after an
6 administrative hearing on the Accusation.

7 JURISDICTION

8 4. This Accusation is brought before the Board, under the authority of the following
9 laws. All section references are to the Business and Professions Code (Code) unless otherwise
10 indicated.

11 5. Section 2227 of the Code states:

12 (a) A licensee whose matter has been heard by an administrative law judge of the
13 Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or
14 whose default has been entered, and who is found guilty, or who has entered into a
stipulation for disciplinary action with the board, may, in accordance with the provisions of
this chapter:

15 (1) Have his or her license revoked upon order of the board.

16 (2) Have his or her right to practice suspended for a period not to exceed one year
upon order of the board.

17 (3) Be placed on probation and be required to pay the costs of probation monitoring
18 upon order of the board.

19 (4) Be publicly reprimanded by the board. The public reprimand may include a
20 requirement that the licensee complete relevant educational courses approved by the board.

21 (5) Have any other action taken in relation to discipline as part of an order of
probation, as the board or an administrative law judge may deem proper.

22 (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical
23 review or advisory conferences, professional competency examinations, continuing
24 education activities, and cost reimbursement associated therewith that are agreed to with the
25 board and successfully completed by the licensee, or other matters made confidential or
privileged by existing law, is deemed public, and shall be made available to the public by
the board pursuant to Section 803.1.

26 6. Section 2234 of the Code states, in pertinent part:

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

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(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....

7. Section 2239, subdivision (a) of the Code states:

(a) 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.

8. Section 2280 of the Code states:

No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such 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.

9. Section 725, subdivision (a) of the Code states:

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.

10. Section 2242, subdivision (a) of the Code states, in pertinent part:

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

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1 11. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
2 adequate and accurate records relating to the provision of services to their patients constitutes
3 unprofessional conduct."

4 12. Section 2021, subdivision (b) of the Code states:

5 Each licensee shall report to the board each and every change of address within 30
6 days after each change, giving both the old and new address. If an address reported to the
7 board at the time of application for licensure or subsequently is a post office box, the
8 applicant shall also provide the board with a street address. If another address is the
9 licensee's address of record, he or she may request that the second address not be disclosed
10 to the public.

11 13. Section 2236 of the Code states, in pertinent part:

12 (a) The conviction of any offense substantially related to the qualifications, functions,
13 or duties of a physician and surgeon constitutes unprofessional conduct within the meaning
14 of this chapter. The record of conviction shall be conclusive evidence only of the fact that
15 the conviction occurred.

16 ...

17 (d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is
18 deemed to be a conviction within the meaning of this section and Section 2236.1. The
19 record of conviction shall be conclusive evidence of the fact that the conviction occurred.

20 FACTS

21 *Impaired Practice and Other Interactions with Board Investigators*

22 14. On or about April 18, 2018, Investigator S.B. (Inv. S.B.) of the State of California,
23 Department of Consumer Affairs, Division of Investigation, Health Quality Investigation
24 Unit (HQIU) presented to Respondent's then address of record with the Board in or around San
25 Diego, California (the Office).

26 15. At approximately 10:20 a.m., Respondent entered the waiting area where Inv. S.B.
27 was present. Respondent addressed two other individuals in the waiting area, explaining to them
28 that he would be with them in a few minutes. Inv. S.B. understood them to be patients of
Respondent awaiting their appointments. Respondent escorted Inv. S.B. back to Respondent's
office.

16. Inv. S.B. observed Respondent walking very slowly and deliberately, and Respondent
appeared to almost lose his balance multiple times. As he talked with Respondent, Inv. S.B.

1 observed that Respondent's speech was slurred and very slow, and that Respondent appeared to
2 think about his words very carefully. Inv. S.B. recognized such conduct as objective symptoms of
3 alcohol intoxication based on Inv. S.B.'s training and experience as a sworn peace officer,
4 including hundreds of encounters with individuals impaired due to alcohol intoxication.

5 17. When Inv. S.B. and Respondent reached Respondent's office, Inv. S.B. observed that
6 the office was in disarray. There were paintings on the floor and leaning against Respondent's
7 desk and cabinets. Cleaning supplies were on the floor and there were numerous objects piled up
8 in the corner behind Respondent's desk. There were also papers on the floor under the wheels of
9 Respondent's chair.

10 18. In Respondent's office, Inv. S.B. asked Respondent when he had last consumed an
11 alcoholic beverage. Respondent stated that he had not had an alcoholic beverage since his parents
12 arrived from Texas in February 2018. Respondent stated that he has no problems with alcohol and
13 that he did not have any alcoholic beverages in his home or office.

14 19. Inv. S.B. asked Respondent about the contents of various pieces of furniture in
15 Respondent's office, including a night stand behind Respondent's desk. Respondent opened the
16 top drawer of the night stand and Inv. S.B. observed a mostly empty 750 mL vodka bottle lying
17 on its side on top of some papers. Respondent stared at the bottle for approximately ten seconds
18 and then began mumbling. Inv. S.B. asked Respondent what type of alcohol was in the bottle and
19 Respondent replied, "vodka."

20 20. Inv. S.B. informed Respondent that he believed Respondent was so intoxicated that
21 Respondent could not practice medicine safely. Respondent asked if he could notify his patients
22 in the waiting area. Inv. S.B. followed Respondent to the waiting area, whereupon he observed
23 Respondent inform two individuals Inv. S.B. understood to be patients that Respondent was sorry
24 but he needed to reschedule their appointments. During the walk to the waiting area, Respondent
25 continued to walk very slowly and deliberately, and also slightly lost his balance.

26 21. Inv. S.B. then observed Respondent appearing to call patients to cancel his
27 appointments for the rest of April 18, 2018, and the following two days (April 19, 2018, and
28 April 20, 2018).

1 22. Additional investigators from HQUIU arrived at Respondent's office and Respondent
2 stated that he had not consumed any alcoholic beverages. Inv. S.B. asked Respondent if he would
3 voluntarily provide a urine sample, which he agreed to do.

4 23. After providing Inv. S.B. a urine sample, Respondent stated that his mother had been
5 giving him a Mexican home remedy to stop his drinking. Respondent stated that the remedy
6 consists of a glass of vodka mixed with fresh cloves. Respondent indicated that he had consumed
7 an approximately eight-ounce glass of the beverage at approximately 6:00 a.m., and another
8 approximately eight-ounce glass of the beverage at approximately 7:00 a.m.

9 24. Respondent removed a tissue from one of his pants pockets, which contained some
10 small dark brown clumps of powder and what appeared to be small twigs. Respondent stated that
11 they were cloves and that he would chew on them during his work day in an attempt to not drink
12 the vodka.

13 25. Inv. S.B. again asked Respondent why his mother was concerned about his drinking
14 and making remedies to help Respondent stop. Respondent stated that a friend had invited him to
15 an Alcoholics Anonymous meeting, and that Respondent had gone to the meeting, but that it was
16 not for him. Respondent stated that he grew up in an era of binge drinking, that he binge drank
17 before his parents arrived from Texas, and that he has a problem with binge drinking.

18 26. Respondent also stated that he has been depressed but has not sought treatment. He
19 stated that he has been taking approximately 600 mg of gabapentin three times a day along with
20 Keppra. Respondent stated that he thinks he is being overdosed with gabapentin and had spoken
21 with his physician about it.

22 27. Officer D.B. of the San Diego Police Department (Officer B.) arrived at the Office.

23 28. Respondent voluntarily agreed to submit to a preliminary alcohol-screening (PAS)
24 test, which would measure his blood alcohol concentration (BAC). Officer B. administered a PAS
25 test on Respondent, which yielded a BAC of .216 percent. Approximately five minutes later,
26 Officer B. again administered a PAS test on Respondent, which yielded a BAC of .201 percent.

27 29. After the administration of the PAS tests, Respondent stated that he sees
28 approximately six or seven patients a day. He stated that he had seen two patients on

1 April 18, 2018 prior to meeting with Inv. S.B., and that he had issued a prescription to one of his
2 patients. Respondent further stated that he needs to get help with his drinking. Based on
3 observations of objective symptoms of intoxication, Respondent's statements, and the PAS test
4 results, the HQIU investigators determined that Respondent was a danger to himself and to others
5 if allowed to continue to practice medicine. Respondent stated that he was closing his office for
6 the rest of the week. Respondent appeared to close his office at approximately 12:40 p.m., and
7 two individuals Inv. S.B. understood to be Respondent's mother and father arrived to pick up
8 Respondent.

9 30. The urine specimen provided by Respondent on or about April 18, 2018 later tested
10 positive for the presence of alcohol and temazepam.¹

11 31. On or about April 30, 2018, Inv. S.B. and another HQIU investigator returned to the
12 Office. During this visit, Respondent refused to provide a urine specimen for the performance of a
13 urine drug screen. Respondent stated that his alcohol of choice is tequila, but that he was only
14 drinking vodka prior to Inv. S.B.'s visit on or about April 18, 2018 as a home remedy to stop
15 drinking.

16 32. Subsequent to the Office of Administrative Hearings' issuance of the Interim
17 Suspension Order on or about May 22, 2018, Inv. S.B. made numerous unsuccessful attempts to
18 contact or locate Respondent.

19 33. Efforts made by Inv. S.B. to contact or locate Respondent in or after May 2018
20 included, but were not limited to, telephone calls to multiple telephone numbers Inv. S.B. knew or
21 believed to be associated with Respondent, and at least one email sent to an email address
22 Inv. S.B. knew or believed to be associated with Respondent. Inv. S.B. received no response from
23 Respondent to these communications.

24 34. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included,
25 but were not limited to, a visit to the Office on or about September 19, 2018. A worker stated to

26 / / / /

27 ¹ Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code
28 section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code
section 4022.

1 Inv. S.B. that Respondent had cleared out his office and left, and that the office space had been
2 rented to another tenant. No forwarding address for Respondent was available.

3 35. Respondent failed to timely notify the Board of his change of address and address of
4 record following his departure from the Office.

5 36. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included,
6 but were not limited to, a visit to a residential address known to Inv. S.B. to have been a prior
7 residence of Respondent. A construction worker at the residence stated to Inv. S.B. that
8 Respondent no longer resided there and that the apartment was being remodeled for another
9 tenant.

10 37. On or about September 21, 2018, Inv. S.B. sent a written request to the United States
11 Postal Service (USPS) requesting a forwarding address for Respondent. Inv. S.B. did not
12 subsequently receive any forwarding address from the USPS.

13 ***Patient A***

14 38. In or around January 2017, "Patient A"² presented to Respondent for psychiatric care
15 and treatment. During the appointment, Respondent gave Patient A one or more boxes of what
16 Patient A understood to be sample medication.

17 39. When Patient A returned home after the appointment, he and his spouse found a
18 small, empty vodka bottle inside a medication sample box that Patient A had received from
19 Respondent.

20 ***Patient B***

21 40. On multiple occasions in or around August 2017 to May 2018, "Patient B" presented
22 to Respondent for psychiatric care and treatment.

23 41. During one or more psychiatric appointments with Respondent in or around
24 August 2017 to May 2018, Patient B observed Respondent exhibiting a sign or symptom of
25 alcohol intoxication during a medical appointment including, but not limited to, the smell of

26 _____
27 ² Patient names are withheld in the instant accusation to preserve the confidentiality of
28 patient medical information. The identity of any patient referenced in this Accusation is known
to Respondent or will be disclosed upon Complainant's receipt of a duly issued request for
discovery from Respondent.

1 alcohol, a flushed face, red, blood shot or blurry eyes, impaired gait or stumbling, slurred speech,
2 difficulty focusing, unresponsiveness, or any combination thereof.

3 42. Subsequent to a psychiatric appointment with Respondent in or about May 2018,
4 Patient B was unable to contact Respondent or determine Respondent's whereabouts.

5 43. Respondent failed to provide Patient B adequate notice of termination of care,
6 physician referral, or other assistance transitioning care to another healthcare provider.

7 44. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail,
8 duly-authorized requests for Patient B's medical records to Respondent addressed to the Office,
9 Respondent's then address of record with the Board.

10 45. On or about October 2, 2018, Inv. S.B. received the returned request for Patient B's
11 medical records that had been sent via certified mail to Respondent, addressed to the Office. The
12 return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO
13 FORWARD[.]" "NOT HERE" was hand-written on the return envelope.

14 46. On or about December 11, 2018, Inv. S.B. received the returned request for
15 Patient B's medical records that had been sent via first-class mail to Respondent, addressed to the
16 Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
17 ADDRESSED[,] UNABLE TO FORWARD[.]"

18 *Patient C*

19 47. On multiple occasions in or around 2012³ to March 2018, "Patient C" presented to
20 Respondent for psychiatric care and treatment.

21 48. During one or more psychiatric appointments with Respondent in or around 2017 or
22 2018, Patient C observed Respondent exhibiting one or more objective signs of intoxication
23 including, but not limited to, slurred speech, repeating statements, half-open eyes, attempting to
24 give Patient C the same prescription multiple times and forgetting that it had already been
25 provided, or any combination thereof.

26 / / / /

27 ³ Any acts or omissions by Respondent alleged herein to have occurred more than seven
28 years prior to the filing date of the instant Accusation are not intended to serve as the basis for
disciplinary action, but rather are provided for informational purposes only.

1 49. On or about October 19, 2018, Inv. S.B. sent, via first-class and certified mail, duly-
2 authorized requests for Patient C’s medical records to Respondent addressed to the Office,
3 Respondent’s then address of record with the Board.

4 50. On or about October 31, 2018, Inv. S.B. received the returned, undelivered request
5 for Patient C’s medical records that had been sent via certified mail to Respondent, addressed to
6 the Office.

7 51. On or about December 11, 2018, Inv. S.B. received the returned request for
8 Patient C’s medical records that had been sent via first-class mail to Respondent, addressed to the
9 Office. The return label read, “RETURN TO SENDER[,] NOT DELIVERABLE AS
10 ADDRESSED[,] UNABLE TO FORWARD[.]”

11 *Patient D*

12 52. On multiple occasions in or around January 2013 to October 2017, “Patient D”
13 presented to Respondent for psychiatric care and treatment.

14 53. During one or more medical appointments in or around January 2013 to
15 October 2017, Respondent disclosed personal or business information to Patient D without a valid
16 therapeutic reason for doing so.

17 54. On one or more occasions during the course of Respondent’s care and treatment of
18 Patient D in or around January 2013 to October 2017, Respondent requested that Patient D post a
19 positive online review of Respondent’s practice to promote his business.

20 55. On multiple occasions during the course of Respondent’s care and treatment of
21 Patient D in or around January 2013 to October 2017, Respondent conducted a medication
22 monitoring appointment for Patient D of insufficient duration, on multiple occasions spending as
23 little as approximately two to five minutes with Patient D.

24 56. On or about May 20, 2014, Patient D presented to Respondent. In his medical record
25 note for this appointment, Respondent failed to adequately establish or document the presence or
26 absence of medication side effects, or perform or document a mental status examination.
27 Respondent also failed to adequately document the medications prescribed to Patient D.

28 / / / /

1 57. Patient D presented to Respondent on or about July 28, 2015 and August 18, 2015. In
2 his medical record notes for these appointments, Respondent documented symptoms of major
3 depression including, but not limited to, a depressed mood, anxiety, poor sleep, irritability,
4 anhedonia, and decreased energy and appetite. However, during these appointments Respondent
5 failed to adequately take or document a history regarding the chronology and nature and extent of
6 Patient D's symptoms, or a history regarding past response to treatment for any previous episodes
7 of major depression.

8 58. On or about July 28, 2015, Respondent prescribed approximately 30 mg per day of
9 Dexedrine⁴ to Patient D. Respondent failed to adequately document a basis for the prescribing of
10 this medication or medication amount.

11 59. In or about September 2015, Patient D presented to Respondent. In his medical record
12 note for this appointment, Respondent documented that the patient was doing great and that she
13 had no problems. Respondent failed to adequately obtain or document a history regarding the
14 disposition of Patient D's previously noted symptoms of major depressive disorder with anxiety
15 and panic attacks.

16 60. On or about June 27, 2016, Patient D presented to Respondent. In his medical record
17 note for this appointment, Respondent documented that Patient D had four to six symptoms of
18 depression, as well as anxiety and panic attacks. However, Respondent failed to adequately take
19 or document a history of the nature and extent of any such symptoms of depression.

20 61. In his medical record note for the appointment with Patient D on or about June 27,
21 2016, Respondent documented Xanax⁵ was one of Patient D's current medications but
22 documented issuing a refill for another benzodiazepine, Klonopin.⁶

23 ⁴ Dexedrine, a brand name for dextroamphetamine, is a Schedule II controlled substance
24 pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug
pursuant to Business and Professions Code section 4022.

25 ⁵ Xanax, a brand name for alprazolam, is a Schedule IV controlled substance pursuant to
26 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
Business and Professions Code section 4022. It is an anti-anxiety medication in the
benzodiazepine family.

27 ⁶ Klonopin, a brand name for clonazepam, is a Schedule IV controlled substance pursuant
28 to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
Business and Professions Code section 4022. It is an anti-anxiety medication in the
benzodiazepine family.

1 and scope of Patient F's post-traumatic stress disorder (PTSD) symptoms, and Patient F's past
2 response to psychotropic medications.

3 79. In his medical record note for the initial intake appointment on or about June 24,
4 2015, Respondent documented that Patient F had a prior suicide attempt, but failed to document
5 the nature of the suicide attempt, the precipitant for it, or when it occurred.

6 80. In his medical record note for the initial intake appointment on or about June 24,
7 2015, Respondent documented that Patient F had a prior psychiatric hospitalization, but failed to
8 adequately document details regarding this hospitalization including, but not limited to, where,
9 when, why and for how long she was hospitalized, whether the hospitalization had any
10 connection to the documented prior suicide attempt, or the nature of the treatment received during
11 the hospitalization.

12 81. In his medical record note for the initial intake appointment on or about June 24,
13 2015, Respondent documented a statement to the effect that all of Patient F's psychotropic
14 medications were increased, without adequate further details including, but not limited to, the
15 new medication dosages, quantities or number of refills.

16 82. On or about August 5, 2015, Patient F presented to Respondent. In his medical record
17 for this appointment, Respondent documented panic attacks as a target symptom for Patient F for
18 the first time. However, Respondent failed to adequately document details regarding the history
19 of any such panic attacks including, but not limited to, the nature and extent of her purported
20 panic attacks or response to treatment.

21 83. On or about November 9, 2015, Patient F presented to Respondent. In his medical
22 record for this appointment, Respondent documented that Patient F had been in a motor vehicle
23 accident and that she had suffered a few scratches. However, Respondent failed to adequately
24 inquire about or document details regarding the accident including, but not limited to, whether
25 Patient F was the driver, sedation from Patient F's medications may have been a contributing
26 factor, or Patient F had combined her medications with alcohol.

27 84. In his medical record for the appointment with Patient F on or about
28 November 9, 2015, Respondent documented that he discontinued a Xanax prescription for

1 Patient F and commenced a Klonopin prescription. However, Respondent failed to document a
2 rationale for this change, the quantity of Klonopin dispensed or prescribed, or the number of
3 refills provided.

4 85. On or about April 7, 2016, Patient F presented to Respondent. Respondent failed to
5 adequately perform or document a mental status examination for this appointment.

6 86. On or about June 9, 2016, Patient F presented to Respondent. In his medical record
7 for this appointment, Respondent documented major depressive disorder (MDD) and generalized
8 anxiety disorder (GAD) in addition to his prior working diagnosis of PTSD. However,
9 Respondent failed to adequately document a rationale for adding MDD and GAD as working
10 diagnoses.

11 87. During an approximately two-month period in or around February 2, 2017 to
12 March 31, 2017, the California Controlled Substance Utilization Review and Evaluation System
13 (CURES) database lists the following prescriptions as having been issued by Respondent and
14 filled by Patient F:

Fill Date	Drug Name	Strength	Quantity	Days Supply
2/2/2017	Clonazepam	1 MG	60	15
2/2/2017	Zolpidem Tartrate ⁷	10 MG	30	30
2/9/2017	Clonazepam	1 MG	60	30
2/9/2017	Zolpidem Tartrate	10 MG	30	30
3/2/2017	Zolpidem Tartrate	10 MG	30	30
3/2/2017	Clonazepam	1 MG	60	15
3/13/2017	Clonazepam	1 MG	60	30
3/13/2017	Zolpidem Tartrate	10 MG	30	30
3/31/2017	Clonazepam	1 MG	60	30
3/31/2017	Zolpidem Tartrate	10 MG	30	30

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25 88. During the approximately two-month period in or around February 2, 2017 to
26 March 31, 2017, the clonazepam and zolpidem tartrate prescriptions filled to Patient F, per the

27 ⁷ Zolpidem, also known as Ambien, Ivadal, Stilnoct or Tilnox, is a Schedule IV controlled
28 substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous
drug pursuant to Business and Professions Code section 4022.

1 CURES database, correspond to prescription dosages that are inconsistent with the dosages
2 documented in Respondent's medical records for Patient F in or around the same period.

3 89. On or about March 13, 2017, Respondent's Office was contacted by a pharmacy
4 regarding a request to fill a prescription issued by Respondent for sixty 1 mg tablets of
5 clonazepam and thirty 10 mg tablets of zolpidem tartrate. Respondent's Office approved the
6 request, but Respondent's medical records for Patient F contain no adequate explanation why the
7 filling of these prescriptions was approved.

8 90. Throughout the course of Respondent's care and treatment of Patient F in or around
9 June 2016 to October 2017, Respondent failed to adequately review, or document adequate
10 review of, the CURES database for controlled substance prescriptions issued to and filled by
11 Patient F.

12 91. On one or more occasions in or around June 2015 to October 2017, Respondent
13 conducted a medication monitoring appointment for Patient F of insufficient duration, on at least
14 one occasion spending as little as approximately two minutes with Patient F.

15 92. On one or more occasions in or around June 2015 to October 2017, Respondent
16 disclosed personal information regarding Respondent to Patient F during a medical appointment
17 without a valid therapeutic reason for doing so.

18 ***Patient G***

19 93. On multiple occasions in or around September 2015 to May 2018, "Patient G"
20 presented to Respondent for psychiatric care and treatment.

21 94. On or about May 31, 2018, Patient G presented to the Office for a scheduled
22 appointment with Respondent. Upon or shortly after arrival, a purported receptionist for another
23 physician stated to Patient G that Respondent and his staff had left the location weeks prior. The
24 receptionist further stated that Respondent had not left a forwarding address and that Patient G
25 would not be able to obtain a copy of her medical records.

26 95. Respondent failed to take adequate steps to notify Patient G regarding the cessation of
27 his practice at the Office.

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1 96. On or about January 10, 2019, Inv. S.B. sent, via first-class and certified mail, duly-
2 authorized requests for Patient G's medical records to Respondent addressed to the Office,
3 Respondent's then address of record with the Board.

4 97. On or about January 22, 2019, Inv. S.B. received the returned request for Patient G's
5 medical records that had been sent, via first-class mail, to Respondent addressed to the Office.
6 The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,]
7 UNABLE TO FORWARD[.]"

8 98. On or about February 28, 2019, Inv. S.B. received the returned, undelivered request
9 for Patient G's medical records that had been sent via certified mail to Respondent, addressed to
10 the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
11 ADDRESSED[,] UNABLE TO FORWARD[.]"

12 *Patient H*

13 99. On multiple occasions in or around September 2016 to April 2018, Patient H
14 presented to Respondent for psychiatric care and treatment.

15 100. In or around April 2018, Patient H presented to the Office for a scheduled
16 appointment with Respondent. When Patient H arrived, he was told by a worker that Respondent
17 had to cancel Patient H's appointment because of an emergency. Patient H received no
18 information regarding a covering physician or referral to another treatment provider.

19 101. Later that day and over the following days, Patient H made multiple attempts to
20 contact Respondent by telephone, text message and e-mail to discuss topics including, without
21 limitation, rescheduling a medical appointment or difficulties that Patient H was experiencing
22 tolerating one or more recently prescribed medications.

23 102. On or about April 25, 2018, Patient H received an email from Respondent in which
24 Respondent stated that he had suffered a seizure and that Respondent was doing his best to get
25 back to his patients.

26 103. Other than the email received on or about April 25, 2018, Patient H did not receive a
27 response to his multiple communication attempts after the cancelled appointment in or around
28 April 2018.

1 104. Patient H received no written notification from Respondent regarding termination of
2 care.

3 105. Following the cancelled appointment with Respondent in or around April 2018,
4 Patient H was unable to access any medical records maintained by Respondent.

5 106. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail,
6 duly-authorized requests for Patient H's medical records to Respondent addressed to the Office,
7 Respondent's then address of record with the Board.

8 107. On or about October 2, 2018, Inv. S.B. received the returned request for Patient H's
9 medical records that had been sent via certified mail to Respondent, addressed to the Office. The
10 return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO
11 FORWARD[.]"

12 108. On or about December 11, 2018, Inv. S.B. received the returned request for
13 Patient H's medical records that had been sent via first-class mail to Respondent, addressed to the
14 Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
15 ADDRESSED[,] UNABLE TO FORWARD[.]"

16 *Patient J*

17 109. On multiple occasions commencing in or around July 2017, "Patient J" presented to
18 Respondent for medical care and treatment.

19 110. On one or more occasions during a medical appointment in or after July 2017,
20 Respondent disclosed personal or business-related information to Patient J without a valid
21 therapeutic reason for doing so.

22 111. In or around June 2018, Patient J attempted to contact Respondent at multiple
23 telephone numbers or email addresses that Patient J had known or reason to believe to be
24 associated with Respondent. Patient J received no response from Respondent.

25 112. In or around June 2018, Patient J mailed a letter to Respondent requesting a copy of
26 his medical records. Patient J received no response and was unable to obtain a copy of his
27 medical records from Respondent.

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1 113. On or about January 15, 2019, Inv. S.B. sent, via first-class and certified mail, duly-
2 authorized requests for Patient J's medical records to Respondent addressed to the Office,
3 Respondent's then address of record with the Board.

4 114. On or about January 29, 2019, Inv. S.B. received the returned request for Patient J's
5 medical records that had been sent via first-class mail to Respondent, addressed to the Office.
6 The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,]
7 UNABLE TO FORWARD[.]"

8 115. On or about February 5, 2019, Inv. S.B. received the returned, undelivered request for
9 Patient J's medical records that had been sent via certified mail to Respondent, addressed to the
10 Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS
11 ADDRESSED[,] UNABLE TO FORWARD[.]"

12 ***Patient K***

13 116. On multiple occasions in or around March 2017 to 2018, "Patient K" received
14 medical care and treatment from Respondent.

15 117. On one or more occasions in the course of Respondent's care and treatment of
16 Patient K in or around March 2017 to 2018, Respondent cried or disclosed personal issues to
17 Patient K during a medical appointment without a valid therapeutic reason for doing so.

18 118. On or about May 8, 2018, Patient K presented to Respondent for a medical
19 appointment at the Office. Upon or shortly after arrival, Patient K observed a sign on a door
20 stating, among other things, that Respondent would be out of the office and that all appointments
21 were cancelled until further notice. The sign stated, "If you need refills please contact your
22 Primary Care Doctor." The sign failed to include any forwarding or other contact information for
23 Respondent.

24 119. Patient K walked through the waiting area back toward Respondent's office.
25 Patient K found Respondent in his office and observed him crying and packing his things.
26 Respondent told Patient K that a staff person had stolen money from him and that the staff person
27 had further gone to a governmental entity and complained that Respondent was seeing patients
28 under the influence of alcohol.

1 120. Subsequent to the May 2018 encounter with Respondent, Patient K found another
2 healthcare provider. However, as late as December 2018, neither Patient K nor the subsequent
3 healthcare provider were able to obtain a copy of Respondent's medical record for Patient K.

4 121. On or about December 17, 2018, Inv. S.B. sent, via first-class and certified mail,
5 duly-authorized requests for Patient K's medical records to Respondent addressed to the Office,
6 Respondent's then address of record with the Board.

7 122. On or about December 31, 2018, Inv. S.B. received the returned requests for Patient
8 K's medical records that had been sent, via first-class and certified mail, to Respondent addressed
9 to the Office. The return labels read, "RETURN TO SENDER[,] ATTEMPTED – NOT
10 KNOWN[,] UNABLE TO FORWARD[.]"

11 ***Guilty Plea to Health Care Fraud***

12 123. On or about August 20, 2019, Respondent pleaded guilty to a felony violation of
13 18 U.S.C., § 1347 (Health Care Fraud) in the case entitled *United States of America v. Marco*
14 *Antonio Chavez*, U.S. District Court, Southern District of California, Case No. 18CR2930L.

15 **FIRST CAUSE FOR DISCIPLINE**

16 **(Use of Drugs or Alcoholic Beverages in a Manner, or to an Extent, as to be Dangerous to**
17 **Himself, to Another Person, or to the Public)**

18 124. Respondent has subjected his Physician's and Surgeon's Certificate No. A 115932 to
19 disciplinary action under sections 2227 and 2234, as defined by section 2239, subdivision (a), of
20 the Code, in that he used or prescribed, or administered to himself, drugs or alcoholic beverages
21 to the extent, or in such manner, as to be dangerous or injurious to him, to another person, or to
22 the public as more particularly alleged in paragraphs 14 to 51, above, which are hereby
23 incorporated by reference and realleged as if fully set forth herein.

24 **SECOND CAUSE FOR DISCIPLINE**

25 **(Practice of Medicine While Under the Influence of Any Narcotic Drug or Alcohol)**

26 125. Respondent has further subjected his Physician's and Surgeon's Certificate
27 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2280, of
28 the Code, in that he practiced medicine while under the influence of any narcotic drug or alcohol

1 to such an extent as to impair his or her ability to conduct the practice of medicine with safety to
2 the public and his or her patients, as more particularly alleged in paragraphs 14 to 51, above,
3 which are hereby incorporated by reference and realleged as if fully set forth herein.

4 **THIRD CAUSE FOR DISCIPLINE**

5 **(Gross Negligence)**

6 126. Respondent has further subjected his Physician's and Surgeon's Certificate
7 No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in
8 that he committed gross negligence in his care and treatment of one or more patients. The
9 circumstances are as follows:

10 127. Paragraphs 32 to 37 and 47 to 122, above, are hereby incorporated by reference and
11 realleged as if fully set forth herein.

12 128. Respondent committed gross negligence in his care and treatment of Patient C
13 including, but not limited to, failing to take adequate steps to provide Patient C or duly authorized
14 third parties access to medical records.

15 129. Respondent committed gross negligence in his care and treatment of Patient D
16 including, but not limited to:

17 (a) Failing to maintain appropriate professional boundaries with Patient D.

18 (b) Conducting one or more medication management appointments of inadequate
19 duration with Patient D.

20 (c) Failing to adequately document details regarding one or more prescriptions
21 issued to Patient D including, but not limited to, the prescription name, quantity, dosage,
22 clinical indication, or any combination thereof.

23 (d) Failing to document or maintain an adequate psychiatric history and record for
24 Patient D.

25 (e) Failing to properly treat Patient D's symptoms of major depression.

26 (f) Concurrently prescribing more than one benzodiazepine to Patient D.

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1 130. Respondent committed gross negligence in his care and treatment of Patient E
2 including, but not limited to, failing to adequately:

3 (a) Provide a copy of Patient E's medical records to Patient E or the public benefits
4 program to which she had applied.

5 (b) Take steps to provide Patient E or duly authorized third parties access to
6 medical records.

7 (c) Take steps to attempt to arrange coverage or a transition of care to another
8 treating psychiatrist once Respondent was unable to provide care to Patient E.

9 131. Respondent committed gross negligence in his care and treatment of Patient F
10 including, but not limited to:

11 (a) Conducting one or more medication monitoring appointments of inadequate
12 duration with Patient F.

13 (b) Failing to maintain appropriate professional boundaries with Patient F.

14 (c) Failing to adequately obtain or document details regarding Patient F's history of
15 a suicide attempt and psychiatric hospitalization.

16 (d) Failing to adequately obtain or document details regarding Patient F's reported
17 panic attacks.

18 (e) Failing to adequately document details regarding prescriptions issued to
19 Patient F.

20 (f) Prescribing controlled substances to Patient F without establishing or
21 documenting adequate medical indication.

22 132. Respondent committed gross negligence in his care and treatment of Patient G
23 including, but not limited to, failing to take adequate steps to provide Patient G or duly authorized
24 third parties access to medical records.

25 133. Respondent committed gross negligence in his care and treatment of Patient H
26 including, but not limited to, failing to take adequate steps to provide Patient H or duly authorized
27 third parties access to medical records.

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1 134. Respondent committed gross negligence in his care and treatment of Patient J
2 including, but not limited to, failing to adequately:

3 (a) Maintain professional boundaries with Patient J.

4 (b) Take steps to provide Patient J or duly authorized third parties access to
5 medical records.

6 135. Respondent committed gross negligence in his care and treatment of Patient K
7 including, but not limited to, failing to adequately:

8 (a) Take steps to provide Patient K or duly authorized third parties access to
9 medical records.

10 (b) Maintain professional boundaries with Patient K.

11 **FOURTH CAUSE FOR DISCIPLINE**

12 **(Repeated Negligent Acts)**

13 136. Respondent has further subjected his Physician's and Surgeon's Certificate
14 No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (c) of the Code in
15 that he committed repeated negligent acts in his care and treatment of one or more patients. The
16 circumstances are as follows:

17 137. Paragraphs 32 to 37, 47 to 122, and 126 to 135, above, are hereby incorporated by
18 reference and realleged as if fully set forth herein.

19 138. Respondent committed additional negligent acts in his care and treatment of Patient D
20 including, but not limited to, failing to provide adequate notice to Patient D regarding termination
21 of care.

22 139. Respondent committed additional negligent acts in his care and treatment of Patient F
23 including, but not limited to, failing to adequately:

24 (a) Obtain or document a general psychiatric history during Patient F's initial
25 intake appointment on or about June 24, 2015.

26 (b) Obtain or document details regarding Patient F's reported motor vehicle
27 accident in or around November 2015.

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1 (c) Document details regarding the change of Patient F's benzodiazepine
2 prescription from Xanax to Klonopin in or about November 2015.

3 (d) Perform or document a mental status examination during Patient F's
4 appointment on or about April 7, 2016.

5 (e) Document a rationale for changing the working diagnoses for Patient F on or
6 about June 9, 2016.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 **(Excessive Prescribing)**

9 140. Respondent has further subjected his Physician's and Surgeon's Certificate
10 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 725,
11 subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing,
12 furnishing, dispensing, or administering of drugs or treatment as more particularly alleged in
13 paragraphs 52 to 67, 77 to 92, 129, and 131, which are hereby incorporated by reference and
14 realleged as if fully set forth herein.

15 **SIXTH CAUSE FOR DISCIPLINE**

16 **(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior
17 Examination and a Medical Indication)**

18 141. Respondent has further subjected his Physician's and Surgeon's Certificate
19 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2242,
20 subdivision (a), of the Code in that he prescribed a dangerous drug without an appropriate prior
21 examination and a medical indication as more particularly alleged in paragraphs 52 to 67, 77
22 to 92, 129, and 131, which are hereby incorporated by reference and realleged as if fully set forth
23 herein.

24 **SEVENTH CAUSE FOR DISCIPLINE**

25 **(Failure to Maintain Adequate and Accurate Records)**

26 142. Respondent has further subjected his Physician's and Surgeon's Certificate
27 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of
28 the Code in that he failed to maintain adequate and accurate records relating to the provision of

1 services to his patients as more particularly alleged in paragraphs 40 to 122 and 126 to 139,
2 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

3 **EIGHTH CAUSE FOR DISCIPLINE**

4 **(Failure to Timely Report a Change of Address to the Board)**

5 143. Respondent has further subjected his Physician's and Surgeon's Certificate
6 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
7 subdivision (a), of the Code in that he violated section 2021, subdivision (b) of the Code by
8 failing to notify the Board of one or more changes of address within 30 days as more particularly
9 alleged in paragraphs 33 to 37 and 40 to 122, above, which are hereby incorporated by reference
10 and realleged as if fully set forth herein.

11 **NINTH CAUSE FOR DISCIPLINE**

12 **(Conviction Related to the Qualifications, Functions or Duties of a Licensee)**

13 144. Respondent has further subjected his Physician's and Surgeon's Certificate
14 No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of
15 the Code in that he was convicted, by his plea of guilty, to an offense substantially related to the
16 qualifications, functions or duties of a licensee as more particularly alleged in paragraph 123,
17 above, which is hereby incorporated by reference and realleged as if fully set forth herein.

18 **TENTH CAUSE FOR DISCIPLINE**

19 **(Violating the Medical Practice Act)**

20 145. Respondent further has subjected his Physician's and Surgeon's Certificate No. A
21 115932 to disciplinary action under sections 2227 and 2234, subdivision (a) in that he violated or
22 attempted to violate, directly or indirectly, one or more provisions of the Medical Practice Act, as
23 more particularly alleged in paragraphs 14 to 144, above, which are hereby incorporated by
24 reference and realleged as if fully set forth herein.

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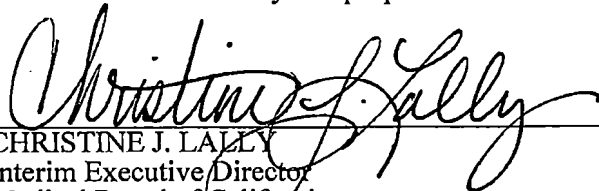
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PRAYER

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 No. A 115932, issued to Respondent Marco Antonio Chavez, M.D.;
2. Revoking, suspending or denying approval of Respondent Marco Antonio Chavez, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent Marco Antonio Chavez, 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 21, 2020


CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant