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

In the Matter of the First Amended Accsuation Against: **Rahima Afghan, M.D.** **770 Magnolia Avenue, Suite 1F** **Corona, CA 92879** **Phsyician's and Surgeon's Certificate No. A 67257,** Respondent.	Case No. 800-2018-049085 OAH Case No. 2022010392 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about January 1, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number A 67257 to Rahima Afghan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or 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:

(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.

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

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

(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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the 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.

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

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

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

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

6. Section 2266 of the Code states:

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

COST RECOVERY

7. Effective on January 1, 2022, section 125.3 of the Code provides:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may

reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.
(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.[1]

DEFINITIONS

8. Alprazolam, sold under the brand name Xanax, is a benzodiazepine depressant used to treat anxiety. Alprazolam is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 11057, subdivision (d)(1).

9. Clonazepam, sold under the brand name Klonopin, is a benzodiazepine depressant used to treat anxiety and seizures. It is a dangerous drug pursuant to Business and Professions

[1] Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians and surgeons from seeking recovery of the costs of investigation and prosecution by the Board, was repealed.

Code section 4022 and a scheduled IV controlled substance pursuant to Health and Safety Code section 11507, subdivision (d)(7).

10. Oxycodone is an opioid narcotic used for relief of moderate to severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

11. Butran patch, also known under the trade name Butrans Patch is an extended release transdermal system that contains the opioid analgesic buprenorphine, and comes in various strengths to treat pain. Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022 and a Schedule V controlled substance pursuant to Health and Safety Code section 11508, subdivision (d).

12. Fentanyl transdermal patch is a transdermal system that contains the opioid analgesic fentanyl, and is used to treat severe pain. Fentanyl, is an opiate, and a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (c)(8).

13. Tylenol #3 is a combination medication that contains acetaminophen and codeine and is used to treat moderate to severe pain. Tylenol #3 is an opiate, and a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule III controlled substance pursuant Health and Safety Code section 11055, subdivision (c)(8).

FACTUAL ALLEGATIONS

14. On or about August 31, 2015, after an extensive review of the latest scientific evidence, the U.S. Food and Drug Administration announced that it is requiring class-wide changes to drug labeling, including patient information, to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines. Among the changes, the FDA required boxed warnings and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these

medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and death.

15. Starting on or about October 2, 2018, Health and Safety Code section 11165.4. (a) (1) (A) (i) requires a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance, to consult the CURES database[2] to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time, and at least once every four months thereafter, if the substance remains part of the treatment of the patient.

Patient 1[3]

16. Respondent began treatment of Patient 1 at the Orange Psychiatric Medical Clinic on or about March 30, 2017, taking over Patient 1's care from another provider. Patient 1's prior provider documented on January 5, 2017, that Patient 1 appeared in distress and in pain, and he noted that she had undergone a previous kidney transplant and suffered from arthritis that caused her knee and neck pain, and that she was taking Percocet. Respondent's assessment of Patient 1 was that she was suffering from a major depressive disorder, and Respondent documented that she reviewed the prior psychiatrist's notes and that Patient 1 appeared anxious and depressed. The bulk of Respondent's chart entries in this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 1's psychological symptoms and did not elicit and document Patient 1's orientation and memory or consideration of any cognitive impairment. On March 30, 2017, Respondent adjusted other psychotropic medications, and continued Patient 1 on the Xanax (alprazolam) regimen established by the previous psychiatrist: .5 mg, to take three a day. Respondent continued this alprazolam regimen through approximately July 12, 2018, at which time alprazolam was reduced to .25 mg, to take three a

[2] CURES stands for Controlled Substance utilization Review and Evaluation System, a prescription drug monitoring program established pursuant to Health and Safety Code section 11165 et seq.

[3] Patients are known to Respondent. They are designated by number for privacy reasons. Their names will be provided to Respondent upon a written Request for Discovery.

day. This regimen continued until approximately October 4, 2018, when Respondent reduced Patient 1's alprazolam .25 mg from three a day to one daily. This continued until approximately January 18, 2019, when Respondent switched Patient 1 from alprazolam to long-acting clonazepam 1 mg daily. Starting approximately on October 10, 2019, Respondent reduced clonazepam to .5 mg daily. This regimen was continued monthly, though January 15, 2020.

17. Simultaneously with Respondent's alprazolam and clonazepam regimen, Patient 1 was also receiving prescriptions for opioid pain medications from other physicians outside of the Orange Psychiatric Medical Clinic. In the three weeks prior to Patient 1's first encounter with Respondent, on or about March 30, 2017, she received a large quantity of high dose oxycodone HCL and acetaminophen 325/10 mg #120 (Percocet), to be taken 4 times per day, as well as the opioid Butran patch (buprenorphine transdermal). Through January 1, 2018, Patient 1 received Percocet and Butran every month from physicians other than Respondent. In February 2018, Butran was discontinued and Patient 1 was prescribed a fentanyl transdermal patch, plus Percocet 325/10 mg 4 times per day, by physicians other than Respondent. As of February, 2018 and continuing through October 10, 2019, Respondent prescribed clonazepam 1 mg daily to Patient 1, and .5 mg daily after October 10, 2019, while she was receiving both fentanyl and Percocet.

18. Respondent's clinical record for Patient 1 makes no mention of the preexisting opioid prescription during that first March 30, 2017 visit. Respondent failed to obtain and/or document a sufficient history from Patient 1, as she failed to elicit and record information about Patient 1's use of opioids for pain for many months. In the notes of the November 2, 2017 encounter, respondent noted that Patient 1 had surgery for esophageal cancer, but there is no elaboration about Patient 1's clinical status, her ability to swallow, her pain levels, or whether Patient 1 used pain medication. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 1's memory or cognition or testing of same. Facility records show that "CURES REPORT was "approved" on July 18, 2018, November 1, 2018, and June 19, 2019, though Respondent made no mention of CURES reports in any of her notes.

19. As of approximately January 18, 2019, Respondent was aware that Patient 1 was using pain medication, as she noted her intention to "stop Xanax add Klonopin [clonazepam] and told her [Patient 1] not to take pain meds at night." On or about March 15, 2019, Respondent once again documented that she "[t]old her [Patient 1] again not to take her pain meds at night." Respondent did not document her reasoning for advising Patient 1 not to take her pain medication at night, whether it was feasible to instruct Patient 1 not to take her pain medications at night, when she was using a long-acting transdermal patch and taking Percocet 4 times a day. Respondent did not contact the doctors who prescribed pain medication in order to coordinate Patient 1's care, and did not document any attempt to make such contacts.

20. On or about June 14, 2019, Respondent noted " ... and next visit will start tapering her [Patient 1] from Klonopin [clonazepam] ... " However, when Patient 1 saw Respondent on or about July 9, 2019, and on August 13, 2019, Respondent continued to prescribe clonazepam at 1 mg daily, without an attempt to taper it. Respondent failed to obtain and/or document Patient 1's informed consent for prescribing of benzodiazepines, especially in light of concomitant dosing of this patient with opioids.

21. During the visit of October 10, 2019, Respondent noted that "Patient is taking a lot of pain meds will up the Effexor lower the Klonopin goal is to finally stop Klonopin." Respondent did not document which pain medicines or how much, Patient 1 was taking. Respondent reduced Patient 1's clonazepam from 1 mg daily to .5 mg daily.

22. Respondent's next visit with Patient 1 was on or about December 10, 2019. Respondent did not mention any prescription for clonazepam in the note for that visit, yet Patient 1 filled Respondent's prescription for clonazepam .5 mg #30 at a pharmacy on December 15, 2019.

23. Respondent's next visit with Patient 1 was on or about January 9, 2020. Respondent did not document any further effort to reduce Patient 1's clonazepam, and a pharmacy dispensed 30 tablets of clonazepam .5 mg, a months' supply, to her, on January 15, 2020.

24. Respondent saw Patient 1 on or about February 6, 2020. In that note Respondent charted that Patient 1 was "... sleeping better without taking Klonopin [clonazepam]."

Patient 2

25. Respondent began treatment of Patient 2, a 54-year-old woman, at the Orange Psychiatric Medical Clinic on or about August 25, 2015. The patient transitioned to Respondent's care from another provider. Respondent noted that Patient 2 "stated doing okay." Respondent documented an assessment of "DEPRESSION, MAJOR, RECURRENT, MODERATE EPISODE (improving)." Respondent noted that she reviewed the prior provider's chart and noted recent medication changes. Respondent also noted that Patient 2 was taking Klonopin 1 mg. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 2's psychological symptoms and did not elicit and document Patient 2's orientation and memory or consideration of any cognitive impairment. At her first visit with Patient 2, on August 25, 2015, Respondent prescribed clonazepam, 1 mg daily.

26. On the next visit, on or about September 22, 2015, Respondent noted that Patient 2 "stated doing well meds are helping denied any depressive symptoms." Respondent also noted that Patient 2 had been taking Klonopin 1 mg tablet at bedtime. On the next visit with Patient 2, on or about November 17, 2015, Respondent noted that she was changing Patient 2's Klonopin regimen; that note indicated that Klonopin 1 mg at bed time "stopped – other – changing." Respondent failed, however, to indicate what change was being made. During the next visit, on or about February 9, 2016, Respondent continued to note that Patient 2 was prescribed Klonopin 1 mg at bedtime. This prescription for clonazepam was renewed at every visit with Patient 2, until February 28, 2017.

27. During the visit with Respondent on December 16, 2016, Respondent wrote: "Pt stated doing okay meds are helping told her will continue with current and she should bring me copy of her labs next year." Respondent did not elaborate what labs she was interested in and for what reason.

28. On the next visit with Patient 2, on or about February 28, 2017, Respondent again documented that "Patient 2 stated doing well no problems." Respondent, however, continued to provide clonazepam to Patient 2. She changed the prescription from 1 mg "1.00 as directed" to .5 mg, "1.00 as directed." Respondent did not elaborate or document in her treatment record precisely what her directions regarding clonazepam were, or why the change was made. However, on March 1, 2017, Patient 2 was dispensed 63 tablets of clonazepam, .5 mg, at a pharmacy, with instructions that she take clonazepam 3 times per day over a 21-day period.

29. Respondent provided 1,071 pills of .5 mg clonazepam over 488 days[4] to Patient 2, who filled prescriptions for 63 tablets of clonazepam, .5 mg, on the following dates: March 1, 2017; April 12, 2017; May 16, 2017; June 4, 2017; August 7, 2017; September 7, 2017; October 13, 2017; October 29, 2017; November 13, 2017; December 11, 2017; January 15, 2018; January 30, 2018; March 30, 2018; April 18, 2018; May 7, 2018; May 26, 2018; June 13, 2018; July 2, 2018; August 28, 2018.

30. During Respondent's visit with Patient 2 on or about August 15, 2017, Respondent noted that "Pt stated emotionally doing well but physically she is in pain." Respondent did not elaborate on the patient's pain complaints and despite those complaints, noted that the patient "is in no distress." Patient 2's medications, including clonazepam, were renewed without changes by Respondent. Respondent saw Patient 2 regularly through April 24, 2021, and her clonazepam was refilled consistently until she was dispensed 63 tablets of .5 mg clonazepam by a pharmacy on August 28, 2018.

31. Patient 2 returned to see Respondent on November 13, 2018. Respondent noted that Patient 2 " stated feeling pretty good no problems. Went to Romania her mother in law was sick. Her insurance covers only 21 days each month." On that date it has been 77 days since August 28, 2018, when Patient 2 was dispensed 63 tablets of .5mg clonazepam. Respondent did not document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2 after a

[4] There are 488 days between March 1, 2017 and July 2, 2018. During that period, not including on July 2, 2018, Patient 2 was dispensed 63 tablets of .5 mg clonazepam 17 times.

pause, when Patient 2 stated that she was feeling "pretty good." Patient 2 was dispensed 63 clonazepam .5 mg tablets on November 13, 2018.

32. Patient 2 returned to see Respondent on February 5, 2019, 84 days later. Respondent noted that Patient 2 was "feeling pretty good no complaints." Patient 2 was dispensed 63 clonazepam .5 mg tablets on February 5, 2019. Respondent did not document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2, when Patient 2 stated that she was feeling "pretty good" and "had no complaints." Patient 2 was dispensed 63 clonazepam .5 mg tablets on February 5, 2019, and 42 tablets of clonazepam .5 mg on May 2, 2019, May 23, 2019, June 19, 2019, July 9, 2019, July 29, 2019, and August 6, 2019.

33. Patient 2 returned to see Respondent on or about August 20, 2019. Respondent noted that "Pt stated feeling pretty good no problems. Pt is taking pain meds so I will start tapering her from Klonopin." When Patient 2 returned to see Respondent on November 12, 2019, Respondent noted that "pt is taking pain meds will lower the Klonopin again. Respondent did not elaborate what "pain meds" the patient was taking, or the manner in which she was planning to lower the Klonopin. Even though Respondent acknowledged that Patient 2 was taking "pain meds" Respondent continued to prescribe clonazepam .5 mg, for Patient 2 to take "as directed," with no information documented about what instructions were given, and no information about what "pain meds" were recorded in the patient's chart. Respondent's intent to lower the patient's Klonopin indicates that Respondent was or should have been aware that Patient 2 was taking opioid pain medications, but no informed consent for prescribing benzodiazepines and concomitant dosing with opioids was ever given or recorded. On August 30, 2019, the patient was dispensed 18 tablets of .5 mg clonazepam; 32 tablets of .5 mg clonazepam on September 12, 2019, October 3, 2019, October 24, 2019, and November 18, 2019; 7 tablets on December 14, 2019, 21 tablets on December 20, 2019, January 8, 2020, February 16, 2020, March 7, 2020, and March 27, 2020.

34. While Respondent was prescribing clonazepam to Patient 2, as described above, Patient 2 was consistently prescribed 60 OxyContin 15 mg and 90 Percocet 325/10 mg, per month by another physician. Respondent failed to obtain and/or document a sufficient history from

Patient 2, as she failed to elicit and record any pertinent information about Patient 2's use of opioids, and prescribed the benzodiazepine clonazepam to Patient 2 concomitantly with opiates. In the patient's chart on August 15, 2017, Respondent noted that Patient 2 was in pain and in her notes of the August 20 and November 12, 2019 Respondent noted that Patient 2 was taking "pain meds" but no where in her records for Patient 2 is there any elaboration about why Patient 2 was in pain, what and/or how much pain medication Patient 2 was taking, or her pain level. No consideration of concomitant prescribing of opiate and benzodiazepine medications is discussed; no informed consent for this combination of medications is discussed or documented. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 2's memory or cognition or perform testing of same. Facility records show that "CURES REPORT was "approved" on November 14, 2018, April 30, 2019 and August 20, 2019, though Respondent made no mention of CURES reports in any of her notes.

Patient 3

35. Patient 3, a 51-year-old woman at the time, was seen by another psychiatrist at Orange Psychiatric Medical Clinic for the first time on February 19, 2016. Patient 3 had been suffering from anxiety for three years, and was being prescribed Xanax (alprazolam) by her primary care physician. The prior provider at Orange Psychiatric Medical Clinic did not document how long Patient 3 was taking Xanax, whether she was taking any other medication, or if she had any other health problems. Patient 3 was assessed with generalized anxiety. Respondent took over the care of Patient 3, on or about March 16, 2016. Respondent did not document how long Patient 3 had been taking Xanax previously, whether she was taking any other medication, or if she had any other health problems. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 3's psychological symptoms and did not elicit and

document Patient 3's orientation and memory or consideration of any cognitive impairment. On the March 16, 2016 visit, and continuing for more than three years, through September 19, 2019, Respondent prescribed alprazolam, 2 mg at bedtime, to Patient 3. Respondent did not obtain and/or document obtaining informed consent for long-term treatment with alprazolam, or for concomitant prescribing of alprazolam with opioid medications. At the first visit Respondent recorded that the patient " ... takes her Xanax 2 mg only at night. That helps not want to change her meds or take any antidepressant."

36. Concomitantly with alprazolam, at least between March 13, 2017 through September 18, 2020, Patient 3 was also receiving from several pharmacies, the opiate pain medication Norco. In addition to Norco, Patient 3 was dispensed Tylenol #3 (acetaminophen with codeine) on October 13, 2017, October 24, 2017, and May 8, 2018.

37. Respondent was aware that Patient 3 was taking opiate pain medications and that she should not take those concomitantly with Xanax. In the chart note of July 18, 2018, Respondent noted that Patient 3 "takes Norco for pain told her she can not mix that with Xanax pt stated she takes Norco in the morning and takes Xanax at night." At the March 16, 2018 session Respondent documented that Patient 3 "was in a car accident 3 weeks ago ... " No details of the circumstances of that accident were obtained or documented. Respondent did not note any injuries or any exacerbation of Patient 3's pain. In fact, Respondent never elicited or recorded any description of Patient 3's pain, or any other reason Patient 3 was taking opiate medications at the same time Respondent was prescribing her a benzodiazepine. Respondent never discussed or recorded Patient 3's opioid dosing, and never obtained and/or documented informed consent for long-term benzodiazepine treatment, or concomitant use of opioid medications and benzodiazepines. On March 9, 2019, Respondent once again documented that Patient 3 "takes her Norco only in the morning does not take it at night when she takes the Xanax." Respondent also noted that Patient 3 suffered a bout of pneumonia, though once again, she elicited and recorded no details about a potential respiratory compromise of a patient who was concomitantly taking opiate and benzodiazepine medications. On June 8, 2019, Respondent again "... told her not to take it ant night." (Sic.) At no time during the course of her care that included a prolonged

use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 3's memory or cognition or perform testing of same.

38. Patient 3's chart contains a chart update dated July 5, 2018, which states that Patient 3's CURES was "printed." A chart update dated June 6, 2019, states, inaccurately, that "CURES checked [Respondent] is the only prescriber." Respondent never acknowledged these chart updates in any of her notes. Respondent did not access CURES herself to review Patient 3's prescribing history.

Patient 4

39. Respondent began to treat Patient 4, a 53-year old woman, on March 7, 2017, at the Orange Psychiatric Medical Clinic. Respondent took over Patient 4's care from another provider. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 4's psychological symptoms and did not elicit and document Patient 4's orientation and memory or consideration of any cognitive impairment. Patient 4 was assessed as suffering from bipolar disorder and, at a later date, Respondent added an assessment of agoraphobia with panic disorder.

40. Starting on March 7, 2017, Respondent prescribed clonazepam 1 mg three times a day to Patient 4. This dose was lowered to 2 tablets of 1 mg clonazepam daily, as of approximately November 13, 2018. Starting on or about August 21, 2020, patient 4 was dispensed 1.5 tablets of clonazepam per day per Respondent's prescription, and starting on or about December 18, 2019, Respondent began to prescribe her 1 tablet of 1 mg clonazepam per day.

41. During this period, other physicians prescribed opioids to treat Patient 4's pain, that overlapped Respondent's prescriptions of clonazepam. Tramadol 50 mg twice per day was dispensed to Patient 4 on September 15, 2017, and the dose was increased significantly on October 20, 2017, but Respondent continued clonazepam without change, prescribing 90 tablets

(3 daily) of 1 mg clonazepam. Respondent noted that Patient 4 appeared depressed during this period, but made no further inquiry and did not comment about the patient's pain.

42. A total of 306 tablets of Percocet 5/325 were dispensed to Patient 4 between March and May, 2019. Despite the overlapping prescriptions of opioids, Respondent did not alter the amount of clonazepam she was prescribing to Patient 4, continuing to prescribe 2 tablets of 1 mg of clonazepam per day. The May 24, 2019, prescription of 40 tablets of Percoet was followed by Respondent prescribing clonazepam 1 mg (two a day) 60 tablets on June 13, 2019.

43. On April 26, 2019, Respondent noted that Patient 4 "stated feeling good no problems. Had knee replacement surgery 7 weeks ago." In Patient 4's chart note on June 20, 2019, Respondent noted that Patient 4 "stated feeling good no problems. Pt is still taking pain meds even now that she had knee replacement surgery so told her will start tapering her from Klonopin and told her in the mean time until she will be off Klonopin she should take pain meds with Klonopin at the same time should take them at least 4 hours apart." Respondent failed to obtain and/or document Patient 4's informed consent to use benzodiazepine medication long term, and/or to use it concomitantly with opioids. Respondent failed to consider and/or make any entries into Patient 4's medical record explaining why Respondent continued to prescribe clonazepam to Patient 4 despite being aware of the concomitant prescriptions of opioids to Patient 4. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 4's memory or cognition or test for same.

44. Patient 4's chart contains notations that Patient 4's CURES report was "OK" or "APPROVED" on January 8, 2019, June 25, 2019, August 16, 2019 and January 28, 2020, though Respondent made no mention of CURES reports in any of her notes.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

45. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code in that she was grossly negligent in her care and treatment of four patients. The circumstances are as follows:

46. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

47. The following acts and omissions by Respondent, taken together or separately represent gross negligence:

A) Respondent's manner of prescribing clonazepam to Patient 1, while Patient 1 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

B) Respondent's manner of prescribing clonazepam to Patient 2, while Patient 2 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

C) Respondent's manner of prescribing alprazolam to Patient 3, while Patient 3 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

D) Respondent's manner of prescribing clonazepam to Patient 4, while Patient 4 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

E) Respondent's failure to utilize CURES in her care and treatment of Patient 1 is an extreme departure from the standard of care.

F) Respondent's failure to utilize CURES in her care and treatment of Patient 2 is an extreme departure from the standard of care.

G) Respondent's failure to utilize CURES in her care and treatment of Patient 3 is an extreme departure from the standard of care.

H) Respondent's failure to utilize CURES in her care and treatment of Patient 4 is an extreme departure from the standard of care.

I) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 1 is an extreme departure from the standard of care.

J) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 2 is an extreme departure from the standard of care.

K) Respondent's dosing and/or long-term prescribing of alprazolam to Patient 3 is an extreme departure from standard of care.

L) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 4 is an extreme departure from the standard of care.

M) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations of Patient 1 is an extreme departure from the standard of care.

N) Respondent's failure to perform and/or document appropriate intake examinationand follow up examinations, including initial and follow up laboratory testing, of Patient 2 is an extreme departure from the standard of care.

O) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 3 is an extreme departure from the standard of care.

P) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 4 is an extreme departure from the standard of care.

Q) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 1 in the manner that she did is an extreme departure from the standard of care.

R) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 2 in the manner that she did is an extreme departure from the standard of care.

S) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 3 in the manner that she did is an extreme departure from the standard of care.

T) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 4 in the manner that she did is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that she committed repeated negligent acts in the care and treatment of four patients. The circumstances are as follows:

49. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

50. Each of the following is a departure from the standard of care.

A) Respondent's manner of prescribing clonazepam to Patient 1, while Patient 1 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

B) Respondent's manner of prescribing clonazepam to Patient 2, while Patient 2 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

C) Respondent's manner of prescribing alprazolam to Patient 3, while Patient 3 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

D) Respondent's manner of prescribing clonazepam to Patient 4, while Patient 4 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

E) Respondent's failure to utilize CURES in her care and treatment of Patient 1 is a departure from the standard of care.

F) Respondent's failure to utilize CURES in her care and treatment of Patient 2 is a departure from the standard of care.

G) Respondent's failure to utilize CURES in her care and treatment of Patient 3 is a departure from the standard of care.

H) Respondent's failure to utilize CURES in her care and treatment of Patient 4 is a departure from the standard of care.

I) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 1 is a departure from the standard of care.

J) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 2 is a departure from the standard of care.

K) Respondent's dosing and/or long-term prescribing of alprazolam to Patient 3 is a departure from standard of care.

L) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 4 is a departure from the standard of care.

M) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 1 is a departure from the standard of care.

N) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 2 is a departure from the standard of care.

O) Respondent's failure to perform and/or document appropriate intake examination, including initial and follow up laboratory testing, and follow up examinations of Patient 3 is a departure from the standard of care.

P) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 4 is a departure from the standard of care.

Q) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 1 in the manner that she did is a departure from the standard of care.

R) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 2 in the manner that she did is a departure from the standard of care.

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S) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 3 in the manner that she did is a departure from the standard of care.

T) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 4 in the manner that she did is a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

51. Respondent Rahima Afghan, M.D. is subject to disciplinary action under Code section 2266 in that Respondent failed to keep adequate and accurate records of the care she rendered to four patients. The circumstances are as follows:

52. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 67257, issued to Rahima Afghan, M.D.;

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

3. Ordering Respondent Rahima Afghan, M.D. to pay the Board reasonable costs of investigation and prosecution incurred after January 1, 2022.

4. Ordering Rahima Afghan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 0 5 2022

Reji Varghese
Deputy Director

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

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