

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

**In the Matter of the First Amended
Accusation Against:**

Rahima Afghan, M.D.

**Physician's and Surgeon's
Certificate No. A 67257**

Respondent.

Case No. 800-2018-049085

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 12, 2023.

IT IS SO ORDERED: December 13, 2022.

MEDICAL BOARD OF CALIFORNIA



**Laurie Rose Lubiano, J.D., Chair
Panel A**

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
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Attorneys for Complainant
7

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

12 In the Matter of the Accusation Against:

13 RAHIMA AFGHAN, M.D.

14 770 Magnolia Avenue, Suite 1F
15 Corona, California 92879

16 Physician's and Surgeon's Certificate No. A
17 67257

18 Respondent.

Case No. 800-2018-049085

OAH No. 2022010392

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

21 **PARTIES**

22 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
23 California (Board). He brought this action solely in his official capacity and is represented in this
24 matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich,
25 Deputy Attorney General.

26 2. Respondent Rahima Afghan, M.D. (Respondent) is represented in this proceeding by
27 attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, CA 92620.
28

1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in First Amended
3 Accusation No. 800-2018-049085, if proven at a hearing, constitute cause for imposing discipline
4 upon her Physician's and Surgeon's Certificate.

5 10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case
6 or factual basis for the charges in the First Amended Accusation, and that Respondent hereby
7 gives up her right to contest those charges.

8 11. Respondent does not contest that, at an administrative hearing, complainant could
9 establish a prima facie case with respect to the charges and allegations in First Amended
10 Accusation No. 800-2018-049085, a true and correct copy of which is attached hereto as Exhibit
11 A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 67257 to
12 disciplinary action.

13 12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to
14 discipline and she agrees to be bound by the Board's probationary terms as set forth in the
15 Disciplinary Order below.

16 CONTINGENCY

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

27 14. Respondent agrees that if she ever petitions for early termination or modification of
28 probation, or if a First Amended Accusation and/or petition to revoke probation is filed against

1 her before the Board, all of the charges and allegations contained in First Amended Accusation
2 No. 800-2018-049085 shall be deemed true, correct and fully admitted by respondent for
3 purposes of any such proceeding or any other licensing proceeding involving Respondent in the
4 State of California.

5 15. The parties understand and agree that Portable Document Format (PDF) and facsimile
6 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
7 signatures thereto, shall have the same force and effect as the originals.

8 16. In consideration of the foregoing admissions and stipulations, the parties agree that
9 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
10 enter the following Disciplinary Order:

11 **DISCIPLINARY ORDER**

12 **IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. A 67257
13 issued to Respondent Rahima Afghan, M.D. is revoked. However, the revocation is stayed and
14 Respondent is placed on probation for three (3) years on the following terms and conditions:

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

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

27 2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
28 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in

1 advance by the Board or its designee. Respondent shall provide the approved course provider
2 with any information and documents that the approved course provider may deem pertinent.
3 Respondent shall participate in and successfully complete the classroom component of the course
4 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
5 complete any other component of the course within one (1) year of enrollment. The prescribing
6 practices course shall be at Respondent's expense and shall be in addition to the Continuing
7 Medical Education (CME) requirements for renewal of licensure.

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

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

16 3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
17 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
18 advance by the Board or its designee. Respondent shall provide the approved course provider
19 with any information and documents that the approved course provider may deem pertinent.
20 Respondent shall participate in and successfully complete the classroom component of the course
21 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
22 complete any other component of the course within one (1) year of enrollment. The medical
23 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
24 Medical Education (CME) requirements for renewal of licensure.

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

1 effective date of this Decision.

2 Respondent shall submit a certification of successful completion to the Board or its
3 designee not later than 15 calendar days after successfully completing the course, or not later than
4 15 calendar days after the effective date of the Decision, whichever is later.

5 4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
6 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
7 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
8 Respondent shall participate in and successfully complete that program. Respondent shall
9 provide any information and documents that the program may deem pertinent. Respondent shall
10 successfully complete the classroom component of the program not later than six (6) months after
11 Respondent's initial enrollment, and the longitudinal component of the program not later than the
12 time specified by the program, but no later than one (1) year after attending the classroom
13 component. The professionalism program shall be at Respondent's expense and shall be in
14 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

15 A professionalism program taken after the acts that gave rise to the charges in the First
16 Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of
17 the Board or its designee, be accepted towards the fulfillment of this condition if the program
18 would have been approved by the Board or its designee had the program been taken after the
19 effective date of this Decision.

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

23 5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the
24 solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice
25 where: 1) Respondent merely shares office space with another physician but is not affiliated for
26 purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that
27 location.

28 If Respondent fails to establish a practice with another physician or secure employment in

1 an appropriate practice setting within 60 calendar days of the effective date of this Decision,
2 Respondent shall receive a notification from the Board or its designee to cease the practice of
3 medicine within three (3) calendar days after being so notified. The Respondent shall not resume
4 practice until an appropriate practice setting is established.

5 If, during the course of the probation, the Respondent's practice setting changes and the
6 Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent
7 shall notify the Board or its designee within five (5) calendar days of the practice setting change.
8 If Respondent fails to establish a practice with another physician or secure employment in an
9 appropriate practice setting within 60 calendar days of the practice setting change, Respondent
10 shall receive a notification from the Board or its designee to cease the practice of medicine within
11 three (3) calendar days after being so notified. The Respondent shall not resume practice until an
12 appropriate practice setting is established.

13 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
14 Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief
15 of Staff or the Chief Executive Officer at every hospital where privileges or membership are
16 extended to Respondent, at any other facility where Respondent engages in the practice of
17 medicine, including all physician and locum tenens registries or other similar agencies, and to the
18 Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage
19 to Respondent. Respondent shall submit proof of compliance to the Board or its designee within
20 15 calendar days.

21 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

22 7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
23 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
24 advanced practice nurses.

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

28 9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby

1 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
2 limited to, expert review, amended First Amended Accusations, legal reviews, investigation(s),
3 and subpoena enforcement, as applicable, in the amount of \$ 8,000 (eight thousand dollars).
4 Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be
5 considered a violation of probation.

6 Payment must be made in full within 30 calendar days of the effective date of the Order, or
7 by a payment plan approved by the Medical Board of California. Any and all requests for a
8 payment plan shall be submitted in writing by respondent to the Board. Failure to comply with
9 the payment plan shall be considered a violation of probation.

10 The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to
11 repay investigation and enforcement costs, including expert review costs (if applicable).

12 10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
13 under penalty of perjury on forms provided by the Board, stating whether there has been
14 compliance with all the conditions of probation.

15 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
16 of the preceding quarter.

17 11. GENERAL PROBATION REQUIREMENTS.

18 Compliance with Probation Unit

19 Respondent shall comply with the Board's probation unit.

20 Address Changes

21 Respondent shall, at all times, keep the Board informed of Respondent's business and
22 residence addresses, email address (if available), and telephone number. Changes of such
23 addresses shall be immediately communicated in writing to the Board or its designee. Under no
24 circumstances shall a post office box serve as an address of record, except as allowed by Business
25 and Professions Code section 2021, subdivision (b).

26 Place of Practice

27 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
28 of residence, unless the patient resides in a skilled nursing facility or other similar licensed

1 facility.

2 License Renewal

3 Respondent shall maintain a current and renewed California physician's and surgeon's
4 license.

5 Travel or Residence Outside California

6 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
7 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
8 (30) calendar days.

9 In the event Respondent should leave the State of California to reside or to practice
10 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
11 departure and return.

12 12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
13 available in person upon request for interviews either at Respondent's place of business or at the
14 probation unit office, with or without prior notice throughout the term of probation.

15 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
16 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
17 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
18 defined as any period of time Respondent is not practicing medicine as defined in Business and
19 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
20 patient care, clinical activity or teaching, or other activity as approved by the Board. If
21 Respondent resides in California and is considered to be in non-practice, Respondent shall
22 comply with all terms and conditions of probation. All time spent in an intensive training
23 program which has been approved by the Board or its designee shall not be considered non-
24 practice and does not relieve Respondent from complying with all the terms and conditions of
25 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
26 on probation with the medical licensing authority of that state or jurisdiction shall not be
27 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
28 period of non-practice.

1 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
2 months, Respondent shall successfully complete the Federation of State Medical Boards's Special
3 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
4 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
5 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

6 Respondent's period of non-practice while on probation shall not exceed two (2) years.

7 Periods of non-practice will not apply to the reduction of the probationary term.

8 Periods of non-practice for a Respondent residing outside of California will relieve
9 Respondent of the responsibility to comply with the probationary terms and conditions with the
10 exception of this condition and the following terms and conditions of probation: Obey All Laws;
11 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
12 Controlled Substances; and Biological Fluid Testing..

13 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
14 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
15 completion of probation. This term does not include cost recovery, which is due within 30
16 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
17 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
18 shall be fully restored.

19 15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
20 of probation is a violation of probation. If Respondent violates probation in any respect, the
21 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
22 carry out the disciplinary order that was stayed. If a First Amended Accusation, or Petition to
23 Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation,
24 the Board shall have continuing jurisdiction until the matter is final, and the period of probation
25 shall be extended until the matter is final.

26 16. LICENSE SURRENDER. Following the effective date of this Decision, if
27 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
28 the terms and conditions of probation, Respondent may request to surrender his or her license.

1 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
2 determining whether or not to grant the request, or to take any other action deemed appropriate
3 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
4 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
5 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
6 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
7 application shall be treated as a petition for reinstatement of a revoked certificate.

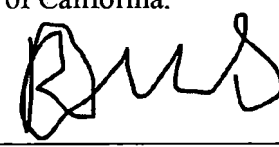
8 17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
9 with probation monitoring each and every year of probation, as designated by the Board, which
10 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
11 California and delivered to the Board or its designee no later than January 31 of each calendar
12 year.

13 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
14 a new license or certification, or petition for reinstatement of a license, by any other health care
15 licensing action agency in the State of California, all of the charges and allegations contained in
16 First Amended Accusation No. 800-2018-049085 shall be deemed to be true, correct, and
17 admitted by Respondent for the purpose of any Statement of Issues or any other proceeding
18 seeking to deny or restrict license.

19
20 ACCEPTANCE

21 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
22 discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect
23 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement
24 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
25 Decision and Order of the Medical Board of California.


26
27 DATED: 8/30/22



28 _____
RAHIMA AFGHAN, M.D.
Respondent

1 I have read and fully discussed with Respondent Rahima Afghan, M.D. the terms and
2 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
3 I approve its form and content.

4 DATED: August 30, 2022


RAYMOND J. MCMAHON
Attorney for Respondent


6
7 **ENDORSEMENT**

8 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
9 submitted for consideration by the Medical Board of California.

10 DATED: August 31, 2022

Respectfully submitted,

11
12 ROB BONTA
Attorney General of California
13 ROBERT MCKIM BELL
Supervising Deputy Attorney General

14 
15 VLADIMIR SHALKEVICH
16 Deputy Attorney General
Attorneys for Complainant

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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accsuation
13 Against:

Case No. 800-2018-049085

14 **Rahima Afghan, M.D.**
15 **770 Magnolia Avenue, Suite 1F**
Corona, CA 92879

OAH Case No. 2022010392

FIRST AMENDED ACCUSATION

16 **Physician's and Surgeon's Certificate**
17 **No. A 67257,**

Respondent.

18
19 **PARTIES**

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

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

27 ///

1 JURISDICTION

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

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

27 5. Section 2234 of the Code, states:

28 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

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

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

8 (d) Incompetence.

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

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

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

16 6. Section 2266 of the Code states:

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

20 COST RECOVERY

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

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

28 (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

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

3 (e) If an order for recovery of costs is made and timely payment is not made as
4 directed in the board's decision, the board may enforce the order for repayment in any
5 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.

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

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

10 (2) Notwithstanding paragraph (1), the board may, in its discretion,
11 conditionally renew or reinstate for a maximum of one year the license of any
12 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.

13 (h) All costs recovered under this section shall be considered a reimbursement for costs
14 incurred and shall be deposited in the fund of the board recovering the costs
to be available upon appropriation by the Legislature.

15 (i) Nothing in this section shall preclude a board from including the recovery of
16 the costs of investigation and enforcement of a case in any stipulated settlement.

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

19 DEFINITIONS

20 8. Alprazolam, sold under the brand name Xanax, is a benzodiazepine depressant used
21 to treat anxiety. Alprazolam is a dangerous drug pursuant to Business and Professions Code
22 section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section
23 11057, subdivision (d)(1).

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

26
27 ¹ Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians
28 and surgeons from seeking recovery of the costs of investigation and prosecution by the
Board, was repealed.

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

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

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

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

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

19 **FACTUAL ALLEGATIONS**

20 14. On or about August 31, 2015, after an extensive review of the latest scientific
21 evidence, the U.S. Food and Drug Administration announced that it is requiring class-wide
22 changes to drug labeling, including patient information, to help inform health care providers and
23 patients of the serious risks associated with the combined use of certain opioid medications and a
24 class of central nervous system (CNS) depressant drugs called benzodiazepines. Among the
25 changes, the FDA required boxed warnings and patient-focused Medication Guides for
26 prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly
27 400 products in total – with information about the serious risks associated with using these
28

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

3 15. Starting on or about October 2, 2018, Health and Safety Code section 11165.4. (a) (1)
4 (A) (i) requires a health care practitioner authorized to prescribe, order, administer, or furnish a
5 controlled substance, to consult the CURES database² to review a patient's controlled substance
6 history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the
7 patient for the first time, and at least once every four months thereafter, if the substance remains
8 part of the treatment of the patient.

9 **Patient 1³**

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

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

28 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.

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

6 17. Simultaneously with Respondent's alprazolam and clonazepam regimen, Patient 1
7 was also receiving prescriptions for opioid pain medications from other physicians outside of the
8 Orange Psychiatric Medical Clinic. In the three weeks prior to Patient 1's first encounter with
9 Respondent, on or about March 30, 2017, she received a large quantity of high dose oxycodone
10 HCL and acetaminophen 325/10 mg #120 (Percocet), to be taken 4 times per day, as well as the
11 opioid Butran patch (buprenorphine transdermal). Through January 1, 2018, Patient 1 received
12 Percocet and Butran every month from physicians other than Respondent. In February 2018,
13 Butran was discontinued and Patient 1 was prescribed a fentanyl transdermal patch, plus Percocet
14 325/10 mg 4 times per day, by physicians other than Respondent. As of February, 2018 and
15 continuing through October 10, 2019, Respondent prescribed clonazepam 1 mg daily to Patient 1,
16 and .5 mg daily after October 10, 2019, while she was receiving both fentanyl and Percocet.

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

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

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

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

20 22. Respondent's next visit with Patient 1 was on or about December 10, 2019.
21 Respondent did not mention any prescription for clonazepam in the note for that visit, yet Patient
22 1 filled Respondent's prescription for clonazepam .5 mg #30 at a pharmacy on December 15,
23 2019.

24 23. Respondent's next visit with Patient 1 was on or about January 9, 2020. Respondent
25 did not document any further effort to reduce Patient 1's clonazepam, and a pharmacy dispensed
26 30 tablets of clonazepam .5 mg, a months' supply, to her, on January 15, 2020.

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

1 **Patient 2**

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

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

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

28

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

8 29. Respondent provided 1,071 pills of .5 mg clonazepam over 488 days⁴ to Patient 2,
9 who filled prescriptions for 63 tablets of clonazepam, .5 mg, on the following dates: March 1,
10 2017; April 12, 2017; May 16, 2017; June 4, 2017; August 7, 2017; September 7, 2017; October
11 13, 2017; October 29, 2017; November 13, 2017; December 11, 2017; January 15, 2018; January
12 30, 2018; March 30, 2018; April 18, 2018; May 7, 2018; May 26, 2018; June 13, 2018; July 2,
13 2018; August 28, 2018.

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

21 31. Patient 2 returned to see Respondent on November 13, 2018. Respondent noted that
22 Patient 2 "stated feeling pretty good no problems. Went to Romania her mother in law was sick.
23 Her insurance covers only 21 days each month." On that date it has been 77 days since August
24 28, 2018, when Patient 2 was dispensed 63 tablets of .5mg clonazepam. Respondent did not
25 document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2 after a
26

27
28 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.

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

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

10 33. Patient 2 returned to see Respondent on or about August 20, 2019. Respondent noted
11 that "Pt stated feeling pretty good no problems. Pt is taking pain meds so I will start tapering her
12 from Klonopin." When Patient 2 returned to see Respondent on November 12, 2019, Respondent
13 noted that "pt is taking pain meds will lower the Klonopin again. Respondent did not elaborate
14 what "pain meds" the patient was taking, or the manner in which she was planning to lower the
15 Klonopin. Even though Respondent acknowledged that Patient 2 was taking "pain meds"
16 Respondent continued to prescribe clonazepam .5 mg, for Patient 2 to take "as directed," with no
17 information documented about what instructions were given, and no information about what
18 "pain meds" were recorded in the patient's chart. Respondent's intent to lower the patient's
19 Klonopin indicates that Respondent was or should have been aware that Patient 2 was taking
20 opioid pain medications, but no informed consent for prescribing benzodiazepines and
21 concomitant dosing with opioids was ever given or recorded. On August 30, 2019, the patient
22 was dispensed 18 tablets of .5 mg clonazepam; 32 tablets of .5 mg clonazepam on September 12,
23 2019, October 3, 2019, October 24, 2019, and November 18, 2019; 7 tablets on December 14,
24 2019, 21 tablets on December 20, 2019, January 8, 2020, February 16, 2020, March 7, 2020, and
25 March 27, 2020.

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

1 Patient 2, as she failed to elicit and record any pertinent information about Patient 2's use of
2 opioids, and prescribed the benzodiazepine clonazepam to Patient 2 concomitantly with opiates.
3 In the patient's chart on August 15, 2017, Respondent noted that Patient 2 was in pain and in her
4 notes of the August 20 and November 12, 2019 Respondent noted that Patient 2 was taking "pain
5 meds" but no where in her records for Patient 2 is there any elaboration about why Patient 2 was
6 in pain, what and/or how much pain medication Patient 2 was taking, or her pain level. No
7 consideration of concomitant prescribing of opiate and benzodiazepine medications is discussed;
8 no informed consent for this combination of medications is discussed or documented. At no time
9 during the course of her care that included a prolonged use of benzodiazepines together with
10 opiates, which was or should have been known to Respondent, did Respondent elicit and/or
11 document any information about Patient 2's memory or cognition or perform testing of same.
12 Facility records show that "CURES REPORT was "approved" on November 14, 2018, April 30,
13 2019 and August 20, 2019, though Respondent made no mention of CURES reports in any of her
14 notes.

15 **Patient 3**

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

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

8 36. Concomitantly with alprazolam, at least between March 13, 2017 through September
9 18, 2020, Patient 3 was also receiving from several pharmacies, the opiate pain medication
10 Norco. In addition to Norco, Patient 3 was dispensed Tylenol #3 (acetaminophen with codeine)
11 on October 13, 2017, October 24, 2017, and May 8, 2018.

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

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

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

9 **Patient 4**

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

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

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

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

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

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

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

24 **FIRST CAUSE FOR DISCIPLINE**

25 **(Gross Negligence)**

26 45. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section
27 2234, subdivision (b) of the Code in that she was grossly negligent in her care and treatment of
28 four patients. The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 48. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section
4 2234, subdivision (c) of the Code in that she committed repeated negligent acts in the care and
5 treatment of four patients. The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

28

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

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

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

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

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

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

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

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

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

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

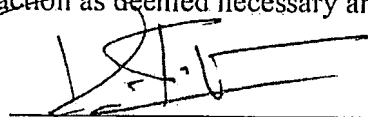
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5. Taking such other and further action as deemed necessary and proper.

DATED: JUL 05 2022


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

Reji Varghese
Deputy Director

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