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

12 In the Matter of the Accusation Against:

Case No. 800-2018-049085

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

A C C U S A T I O N

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

17 Respondent.

18
19 **PARTIES**

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

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1 JURISDICTION

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

2 (2) When the standard of care requires a change in the diagnosis, act, or
3 omission that constitutes the negligent act described in paragraph (1), including, but
4 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.

5 (d) Incompetence.

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

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

9 (g) The failure by a certificate holder, in the absence of good cause, to attend
10 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.

11 6. Section 2266 of the Code states:

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

14 **DEFINITIONS**

15 7. Alprazolam, sold under the brand name Xanax, is a benzodiazepine depressant used
16 to treat anxiety. Alprazolam is a dangerous drug pursuant to Business and Professions Code
17 section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section
18 11057, subdivision (d)(1).

19 8. Clonazepam, sold under the brand name Klonopin, is a benzodiazepine depressant
20 used to treat anxiety and seizures. It is a dangerous drug pursuant to Business and Professions
21 Code section 4022 and a scheduled IV controlled substance pursuant to Health and Safety Code
22 section 11507, subdivision (d)(7).

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

26 10. Butran patch, also known under the trade name Butrans Patch is an extended release
27 transdermal system that contains the opioid analgesic buprenorphine, and comes in various
28 strengths to treat pain. Buprenorphine is a dangerous drug pursuant to Business and Professions

1 Code section 4022 and a Schedule V controlled substance pursuant to Health and Safety Code
2 section 11508, subdivision (d).

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

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

11 **FACTUAL ALLEGATIONS**

12 13. On or about August 31, 2015, after an extensive review of the latest scientific
13 evidence, the U.S. Food and Drug Administration announced that it is requiring class-wide
14 changes to drug labeling, including patient information, to help inform health care providers and
15 patients of the serious risks associated with the combined use of certain opioid medications and a
16 class of central nervous system (CNS) depressant drugs called benzodiazepines. Among the
17 changes, the FDA required boxed warnings and patient-focused Medication Guides for
18 prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly
19 400 products in total – with information about the serious risks associated with using these
20 medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and
21 death.

22 14. Starting on or about October 2, 2018, Health and Safety Code section 11165.4. (a) (1)
23 (A) (i) requires a health care practitioner authorized to prescribe, order, administer, or furnish a
24 controlled substance, to consult the CURES database¹ to review a patient's controlled substance
25 history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the

26 _____
27 ¹ CURES stands for Controlled Substance utilization Review and Evaluation System, a
28 prescription drug monitoring program established pursuant to Health and Safety Code section
11165 et seq.

1 patient for the first time, and at least once every four months thereafter, if the substance remains
2 part of the treatment of the patient.

3 **Patient 1²**

4 15. Respondent began treatment of Patient 1 at the Orange Psychiatric Medical Clinic on
5 or about March 30, 2017, taking over Patient 1's care from another provider. Patient 1's prior
6 provider documented on January 5, 2017, that Patient 1 appeared in distress and in pain, and he
7 noted that she had undergone a previous kidney transplant and suffered from arthritis that caused
8 her knee and neck pain, and that she was taking Percocet.² Respondent's assessment of Patient 1
9 was that she was suffering from a major depressive disorder, and Respondent documented that
10 she reviewed the prior psychiatrist's notes and that Patient 1 appeared anxious and depressed.
11 The bulk of Respondent's chart entries in this patient's medical record appeared to be "copy and
12 pasted" from prior entries and contained minimum clinical information. Respondent never
13 ordered laboratory testing nor obtained and documented current laboratory test results from other
14 clinicians to rule out any possible physiological causes for Patient 1's psychological symptoms
15 and did not elicit and document Patient 1's orientation and memory or consideration of any
16 cognitive impairment. On March 30, 2017, Respondent adjusted other psychotropic medications,
17 and continued Patient 1 on the Xanax (alprazolam) regimen established by the previous
18 psychiatrist: .5 mg, to take three a day. Respondent continued this alprazolam regimen through
19 approximately July 12, 2018, at which time alprazolam was reduced to .25 mg, to take three a
20 day. This regimen continued until approximately October 4, 2018, when Respondent reduced
21 Patient 1's alprazolam .25 mg from three a day to one daily. This continued until approximately
22 January 18, 2019, when Respondent switched Patient 1 from alprazolam to long-acting
23 clonazepam 1 mg daily. Starting approximately on October 10, 2019, Respondent reduced
24 clonazepam to .5 mg daily. This regimen was continued monthly, though January 15, 2020.

25 16. Simultaneously with Respondent's alprazolam and clonazepam regimen, Patient 1
26 was also receiving prescriptions for opioid pain medications from other physicians outside of the

27 _____
28 ² 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 Orange Psychiatric Medical Clinic. In the three weeks prior to Patient 1's first encounter with
2 Respondent, on or about March 30, 2017, she received a large quantity of high dose oxycodone
3 HCL and acetaminophen 325/10 mg #120 (Percocet), to be taken 4 times per day, as well as the
4 opioid Butran patch (buprenorphine transdermal). Through January 1, 2018, Patient 1 received
5 Percocet and Butran every month from physicians other than Respondent. In February 2018,
6 Butran was discontinued and Patient 1 was prescribed a fentanyl transdermal patch, plus Percocet
7 325/10 mg 4 times per day, by physicians other than Respondent. As of February, 2018 and
8 continuing through October 10, 2019, Respondent prescribed clonazepam 1 mg daily to Patient 1,
9 and .5 mg daily after October 10, 2019, while she was receiving both fentanyl and Percocet.

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

22 18. As of approximately January 18, 2019, Respondent was aware that Patient 1
23 was using pain medication, as she noted her intention to "stop Xanax add Klonopin [clonazepam]
24 and told her [Patient 1] not to take pain meds at night." On or about March 15, 2019, Respondent
25 once again documented that she "[t]old her [Patient 1] again not to take her pain meds at night."
26 Respondent did not document her reasoning for advising Patient 1 not to take her pain medication
27 at night, whether it was feasible to instruct Patient 1 not to take her pain medications at night,
28 when she was using a long-acting transdermal patch and taking Percocet 4 times a day.

1 Respondent did not contact the doctors who prescribed pain medication in order to coordinate
2 Patient 1's care, and did not document any attempt to make such contacts.

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

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

13 21. Respondent's next visit with Patient 1 was on or about December 10, 2019.
14 Respondent did not mention any prescription for clonazepam in the note for that visit, yet Patient
15 1 filled Respondent's prescription for clonazepam .5 mg #30 at a pharmacy on December 15,
16 2019.

17 22. Respondent's next visit with Patient 1 was on or about January 9, 2020. Respondent
18 did not document any further effort to reduce Patient 1's clonazepam, and a pharmacy dispensed
19 30 tablets of clonazepam .5 mg, a months' supply, to her, on January 15, 2020.

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

22 **Patient 2**

23 24. Respondent began treatment of Patient 2, a 54-year-old woman, at the Orange
24 Psychiatric Medical Clinic on or about August 25, 2015. The patient transitioned to
25 Respondent's care from another provider. Respondent noted that Patient 1 "stated doing okay."
26 Respondent documented an assessment of "DEPRESSION, MAJOR, RECURRENT,
27 MODERATE EPISODE (improving)." Respondent noted that she reviewed the prior provider's
28 chart and noted recent medication changes. Respondent also noted that Patient 2 was taking

1 Klonopin 1 mg. The bulk of Respondent's chart entries into this patient's medical record
2 appeared to be "copy and pasted" from prior entries and contained minimum clinical information.
3 Respondent never ordered laboratory testing nor obtained and documented current laboratory test
4 results from other clinicians to rule out any possible physiological causes for Patient 2's
5 psychological symptoms and did not elicit and document Patient 2's orientation and memory or
6 consideration of any cognitive impairment. At her first visit with Patient 2, on August 25, 2015,
7 Respondent prescribed clonazepam, 1 mg daily.

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

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

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

1 28. Respondent provided 1,071 pills of .5 mg clonazepam over 488 days³ to Patient 2,
2 who filled prescriptions for 63 tablets of clonazepam, .5 mg, on the following dates: March 1,
3 2017; April 12, 2017; May 16, 2017; June 4, 2017; August 7, 2017; September 7, 2017; October
4 13, 2017; October 29, 2017; November 13, 2017; December 11, 2017; January 15, 2018; January
5 30, 2018; March 30, 2018; April 18, 2018; May 7, 2018; May 26, 2018; June 13, 2018; July 2,
6 2018; August 28, 2018.

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

14 30. Patient 2 returned to see Respondent on November 13, 2018. Respondent noted that
15 Patient 2 "stated feeling pretty good no problems. Went to Romania her mother in law was sick.
16 Her insurance covers only 21 days each month." On that date it has been 77 days since August
17 28, 2018, when Patient 2 was dispensed 63 tablets of .5mg clonazepam. Respondent did not
18 document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2 after a
19 pause, when Patient 2 stated that she was feeling "pretty good." Patient 2 was dispensed 63
20 clonazepam .5 mg tablets on November 13, 2018.

21 31. Patient 2 returned to see Respondent on February 5, 2019, 84 days later. Respondent
22 noted that Patient 2 was "feeling pretty good no complaints." Patient 2 was dispensed 63
23 clonazepam .5 mg tablets on February 5, 2019. Respondent did not document, or elaborate in any
24 way, why she continued prescribing clonazepam to Patient 2, when Patient 2 stated that she was
25 feeling "pretty good" and "had no complaints." Patient 2 was dispensed 63 clonazepam .5 mg
26
27

28 ³ 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 tablets on February 5, 2019, and 42 tablets of clonazepam .5 mg on May 2, 2019, May 23, 2019,
2 June 19, 2019, July 9, 2019, July 29, 2019, and August 6, 2019,

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

19 33. While Respondent was prescribing clonazepam to Patient 2, as described above,
20 Patient 2 was consistently prescribed 60 OxyContin 15 mg and 90 Percocet 325/10 mg, per month
21 by another physician. Respondent failed to obtain and/or document a sufficient history from
22 Patient 2, as she failed to elicit and record any pertinent information about Patient 2's use of
23 opioids, and prescribed the benzodiazepine clonazepam to Patient 2 concomitantly with opiates.
24 In the patient's chart on August 15, 2017, Respondent noted that Patient 2 was in pain and in her
25 notes of the August 20 and November 12, 2019 Respondent noted that Patient 2 was taking "pain
26 meds" but no where in her records for Patient 2 is there any elaboration about why Patient 2 was
27 in pain, what and/or how much pain medication Patient 2 was taking, or her pain level. No
28 consideration of concomitant prescribing of opiate and benzodiazepine medications is discussed;

1 no informed consent for this combination of medications is discussed or documented. At no time
2 during the course of her care that included a prolonged use of benzodiazepines together with
3 opiates, which was or should have been known to Respondent, did Respondent elicit and/or
4 document any information about Patient 2's memory or cognition or perform testing of same.
5 Facility records show that "CURES REPORT was "approved" on November 14, 2018, April 30,
6 2019 and August 20, 2019, though Respondent made no mention of CURES reports in any of her
7 notes.

8 **Patient 3**

9 34. Patient 3, a 51-year-old woman at the time, was seen by another psychiatrist at
10 Orange Psychiatric Medical Clinic for the first time on February 19, 2016. Patient 3 had been
11 suffering from anxiety for three years, and was being prescribed Xanax (alprazolam) by her
12 primary care physician. The prior provider at Orange Psychiatric Medical Clinic did not
13 document how long Patient 3 was taking Xanax, whether she was taking any other medication, or
14 if she had any other health problems. Patient 3 was assessed with generalized anxiety.
15 Respondent took over the care of Patient 3, on or about March 16, 2016. Respondent did not
16 document how long Patient 3 had been taking Xanax previously, whether she was taking any
17 other medication, or if she had any other health problems. The bulk of Respondent's chart entries
18 into this patient's medical record appeared to be "copy and pasted" from prior entries and
19 contained minimum clinical information. Respondent never ordered laboratory testing nor
20 obtained and documented current laboratory test results from other clinicians to rule out any
21 possible physiological causes for Patient 3's psychological symptoms and did not elicit and
22 document Patient 3's orientation and memory or consideration of any cognitive impairment. On
23 the March 16, 2016 visit, and continuing for more than three years, through September 19, 2019,
24 Respondent prescribed alprazolam, 2 mg at bedtime, to Patient 3. Respondent did not obtain
25 and/or document obtaining informed consent for long-term treatment with alprazolam, or for
26 concomitant prescribing of alprazolam with opioid medications. At the first visit Respondent
27 recorded that the patient " ... takes her Xanax 2 mg only at night. That helps not want to change
28 her meds or take any antidepressant."

1 35. Concomitantly with alprazolam, at least between March 13, 2017 through September
2 18, 2020, Patient 3 was also receiving from several pharmacies, the opiate pain medication
3 Norco. In addition to Norco, Patient 3 was dispensed Tylenol #3 (acetaminophen with codeine)
4 on October 13, 2017, October 24, 2017, and May 8, 2018.

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

25 37. Patient 3's chart contains a chart update dated July 5, 2018, which states that Patient
26 3's CURES was "printed." A chart update dated June 6, 2019, states, inaccurately, that "CURES
27 checked [Respondent] is the only prescriber." Respondent never acknowledged these chart
28

1 updates in any of her notes. Respondent did not access CURES herself to review Patient 3's
2 prescribing history.

3 **Patient 4**

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

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

19 40. During this period, other physicians prescribed opioids to treat Patient 4's pain, that
20 overlapped Respondent's prescriptions of clonazepam. Tramadol 50 mg twice per day was
21 dispensed to Patient 4 on September 15, 2017, and the dose was increased significantly on
22 October 20, 2017, but Respondent continued clonazepam without change, prescribing 90 tablets
23 (3 daily) of 1 mg clonazepam. Respondent noted that Patient 4 appeared depressed during this
24 period, but made no further inquiry and did not comment about the patient's pain.

25 41. A total of 306 tablets of Percocet 5/325 were dispensed to Patient 4 between March
26 and May, 2019. Despite the overlapping prescriptions of opioids, Respondent did not alter the
27 amount of clonazepam she was prescribing to Patient 4, continuing to prescribe 2 tablets of 1 mg
28

1 of clonazepam per day. The May 24, 2019, prescription of 40 tablets of Percoet was followed by
2 Respondent prescribing clonazepam 1 mg (two a day) 60 tablets on June 13, 2019.

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

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

19 **FIRST CAUSE FOR DISCIPLINE**

20 **(Gross Negligence)**

21 44. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section
22 2234, subdivision (b) of the Code in that she was grossly negligent in her care and treatment of
23 four patients. The circumstances are as follows:

24 45. The allegations of paragraphs 13 through 43 are incorporated herein by reference.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 47. 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 48. The allegations of paragraphs 13 through 43 are incorporated herein by reference.

7 49. 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.

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

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

7 **THIRD CAUSE FOR DISCIPLINE**

8 **(Record Keeping)**

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

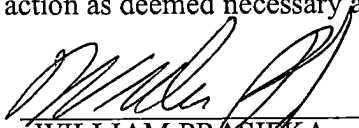
12 51. The allegations of paragraphs 13 through 43 are incorporated herein by reference.

13 **PRAYER**

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

- 16 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 67257,
17 issued to Rahima Afghan, M.D.;
- 18 2. Revoking, suspending or denying approval of Rahima Afghan, M.D.'s authority to
19 supervise physician assistants and advanced practice nurses;
- 20 3. Ordering Rahima Afghan, M.D., if placed on probation, to pay the Board the costs of
21 probation monitoring; and
- 22 4. Taking such other and further action as deemed necessary and proper.

23 DATED: **AUG 11 2021**

24 
25 WILLIAM PRASIFKA
26 Executive Director
27 Medical Board of California
28 Department of Consumer Affairs
State of California
Complainant

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