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

In the Matter of the Accusation Against: **Dwight William Sievert, M.D. 7766 N. Palm Ave., Ste. 107 Fresno, CA 93711-5734** **Physician's and Surgeon's Certificate No. G 47593,** Respondent.	Case No. 800-2020-067784 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 14, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 47593 to Dwight William Sievert, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

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

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

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

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

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS[1]

Circumstances Related to Patient 1

8. On or about October 13, 2018, Patient 1[2] presented to Respondent with a chief complaint of "anxiety, depressed mood, irritable, appetite disturbance, low energy, fatigue."

[1] Events occurring outside the statute of limitations period are described for background purposes only.

[2] Patient names are redacted to protect their privacy.

Further complaints included inability to sleep despite fatigue. Respondent did not document current medications, medication allergies, or past medical history. A diagnosis of "Lymes and Epstein Barr virus" was entered into the chart but Respondent did not document any additional information about these conditions. Respondent diagnosed major depressive disorder, severe, recurrent, and prescribed Pristiq, an antidepressant medication, and temazepam 30 mg, a sedative hypnotic benzodiazepine medication and Schedule IV controlled substance

9. Patient 1 followed up in November 2018 and January 2019, and Respondent continued the patient's medications. On or about February 12, 2019, Respondent discontinued Pristiq, and eszopiclone, a nonbenzodiazepine sedative and Schedule IV controlled substance, was added to temazepam to address continued complaints of insomnia. On or about July 22, 2019, Respondent added the antidepressant bupropion extended release. The records do not contain any notation that the CURES database was consulted prior to prescribing. The final visit occurred in September 2019.

10. The CURES patient profile for Patient 1 indicates that from December 2019 through April 2020, Respondent continued to prescribe eszopiclone and temazepam despite no documented visits occurring during that time. Respondent was aware that the patient had been prescribed Tramadol, a Schedule IV narcotic medication, in October 2018 by another provider, after his initial prescription for temazepam and before his subsequent prescription of temazepam in January 2019; however, Respondent did not note this fact in his records. When interviewed, Respondent stated in regard to combining Tramadol and temazepam, "I don't know that it's the best idea to take them at the same time, but I don't know that it would hurt anything."

Circumstances Related to Patient 2

11. Patient 2 first presented to Respondent in 2011. Respondent treated Patient 2 for complaints of depression and anxiety. Respondent initially prescribed the antidepressants Cymbalta and Wellbutrin XL (bupropion), the atypical antipsychotic Latuda, and the Schedule IV benzodiazepine clonazepam, 2 mg twice a day. On or about July 14, 2015, Respondent added a prescription for the benzodiazepine temazepam 30 mg capsule, one capsule at bedtime as needed for sleep, thirty capsules with three refills, although the clinical record contains no documentation

of the indication for temazepam, the reason for use, consideration of alternatives, or counseling regarding temazepam in combination with clonazepam. Several subsequent medical records appear to be copied forward without modifications. On or about October 19, 2016, an additional prescription for the Schedule IV benzodiazepine alprazolam 1 mg tablet four times per day was entered into the record without documentation of the indication for this medication, consideration of alternatives, or documentation of counseling regarding the risk of combining alprazolam with clonazepam and temazepam. The concomitant prescribing of alprazolam, clonazepam, and temazepam was active from June 3, 2019 through at least April 15, 2020.

12. On or about November 17, 2016, Respondent changed Patient 2's diagnosis to "attention deficit disorder" and "bipolar II disorder" without any documentation of new symptoms that led to a change in diagnosis. At the next visit, on or about December 15, 2016, the diagnosis was reverted to major depressive disorder without a documentation of new symptoms or objective findings supporting a change in diagnosis.

13. From October 9, 2013 through December 5, 2018, there was no documentation of any objective observations or mental status examination. The first such documentation in the records was on or about December 5, 2018. However, following this record the progress notes did not contain any further documentation of medications prescribed to the patient, medication reconciliation, or medical assessments related to the treatment being provided by Respondent. On or about December 10, 2020, the progress note contains a reference to treatment with the Schedule IV stimulant armodafinil, but there is no mention in prior notes related to armodafinil. The CURES report for this patient shows that the first prescription for armodafinil was filled on or about November 3, 2020, prescribed by Respondent. The final record was dated February 10, 2021 and does not contain a medication list or medication reconciliation.

14. When interviewed, Respondent indicated that he felt there was no risk to Patient 2 of prescribing three benzodiazepines at once. He indicated that he had checked CURES reports on this patient. The CURES report indicated that the patient was receiving regular prescriptions for the Schedule II opioid hydrocodone/acetaminophen from a different physician. Respondent did not document awareness of this fact in his records. In the interview, Respondent indicated that to

his knowledge, the patient was not on other narcotic medications. Additionally, he stated that due to concerns about the combination of benzodiazepines, the treatment was consolidated to "just the alprazolam" but the CURES record indicated that in 2021, temazepam was replaced by eszopiclone while clonazepam and alprazolam were continued, along with the armodafinil, presumably to address excessive sedation caused by three sedative-hypnotic agents and hydrocodone, but none of these changes were clearly documented.

Circumstances Related to Patient 3

15. Patient 3 was first seen by a nurse practitioner in Respondent's office in 2013. Listed diagnoses included attention deficit hyperactivity disorder, schizoaffective disorder, bipolar II disorder, chronic post-traumatic stress disorder, and severe recurrent depression without psychotic features. At later points diagnoses were changed to include borderline and narcissistic personality disorders, unspecified mood disorder and unspecified anxiety disorder, and some of the other diagnoses were dropped from the records.

16. After August 2014, Patient 3 was seen by Respondent. She was treated with Adderall (mixed amphetamine salts, a Schedule II controlled substance), the antipsychotic Abilify, the antidepressant Cymbalta, and clonazepam. From 2014 through 2017, she was also treated with the Schedule II psychostimulant Ritalin (methylphenidate). On or about September 12, 2017 Respondent documented that she was overusing prescription Adderall and running out early, and that the patient felt that she was unable to control her use of Adderall. For a few months thereafter, Respondent prescribed armodafinil as a substitute for other psychostimulants. On or about February 19, 2018, Ritalin was restarted despite the patient's recent difficulty controlling her use of stimulant medications. On or about May 10, 2019, Adderall was restarted but later discontinued as she was again unable to control her use. After 2020, the progress notes did not contain medication lists or medication reconciliation. The patient's complaints were vague and focused on external stressors. The notes indicated that medications were continued without identification of which medications were being used, or what were the target symptoms and indications for pharmacotherapy.

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17. On or about June 5, 2020, Respondent documented that Patient 3 had suicidal urges and had considered self-referral to the emergency room. She indicated that she was no longer suicidal. The progress note does not contain any information about a suicide risk assessment or consideration of changes in management given the patient's apparently worsening clinical status.

18. There were also handwritten notes found in the chart from on or about December 1, 2015 through on or about June 5, 2020, which contain brief notes about Patient 3's report and lists of medications. The final handwritten note indicates medications included armodafinil 450 mg per day, Ritalin 20 mg, four times a day, Cymbalta 120 mg daily, and Wellbutrin XL 450 mg daily.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in act(s) and/or omission(s) amounting to gross negligence. The circumstances are set forth in paragraphs 8 through 18, above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

20. The standard of care requires that controlled substances be prescribed at the lowest effective dose, with frequent re-evaluation of the need for controlled substances, and discontinuation of ineffective controlled substances. The standard of care for prescription of controlled substances requires periodic review of the efficacy of treatment. It is unusual to simultaneously prescribe the benzodiazepine sedative temazepam and the nonbenzodiazepine sedative eszopiclone. Respondent's simultaneous prescription of these two medications to Patient 1 from December 2019 through April 2020, during a period when the patient was apparently unstable and symptomatic, without a single documented visit or medical examination, constitutes an extreme departure from the standard of care.

21. Benzodiazepines such as clonazepam, temazepam, and alprazolam are sedating medications used to reduce anxiety or promote sleep and are not indicated for the treatment of major depressive disorder. At various points, from on or about July 20, 2017, through October

2021, Respondent prescribed clonazepam 1 mg four times a day, temazepam 30 mg daily, and alprazolam 1 mg, 4 times a day to Patient 2, who had a documented diagnosis of major depressive disorder, recurrent, severe. There was no documented indication for these medications, either individually or collectively. Clonazepam is specifically contraindicated for patients with "depressed neuroses." The doses prescribed to Patient 2 were moderate to high, and in combination these medications risked excessive sedation and potentially fatal respiratory depression. Respondent's excessive prescribing of multiple simultaneous high dose benzodiazepines to Patient 2 constitutes an extreme departure from the standard of care.

22. The standard of care requires documentation of medications prescribed and the medical decision-making process justifying prescription of controlled substances. Respondent's failure to document the medications prescribed and his reasoning for prescribing multiple simultaneous benzodiazepines to Patient 2 constitutes an extreme departure from the standard of care.

23. In addition to three simultaneous benzodiazepines, Respondent prescribed the stimulant armodafinil to Patient 2, apparently to counteract excessive sedation. Respondent's simultaneous prescription of multiple benzodiazepines with a stimulant constitutes an extreme departure from the standard of care.

24. The standard of care requires a complete diagnostic assessment of mental illness using standard psychiatric criteria. Respondent documented a variety of diagnoses of mental illness in Patient 3, without documenting any specific symptoms or any analysis supporting those diagnoses. Certain diagnoses, such as bipolar II disorder and major depressive disorder, are mutually exclusive. Respondent's inadequate diagnostic assessment of Patient 3 constitutes an extreme departure from the standard of care.

25. On or about July 17, 2017, Respondent prescribed Adderall to Patient 3 with directions to take 40 mg three times per day, which is double the recommended maximum dose. Respondent simultaneously prescribed clonazepam, which suggests that the Adderall prescription was contributing to the patient's anxiety. Respondent also prescribed the antipsychotic medication risperidone, which suggests that the patient was experiencing psychotic symptoms

that could be exacerbated by Adderall. Respondent did not document any medical decision making process justifying these prescriptions. Respondent's excessive prescription of Adderall to Patient 3 without a medical indication constitutes an extreme departure from the standard of care.

26. When a patient under the care of a psychiatrist discloses suicidal urges, suicidal ideation, suicidal impulses, or suicidal behaviors, the standard of care requires the psychiatrist to complete an adequate suicide risk assessment and formulate a medical opinion about a safe level of care and appropriate treatment plan for addressing the suicidal risk. A comprehensive suicide risk assessment includes an assessment of the chronic risk factors for suicide, which are those that cannot be addressed directly through medical interventions such as age, gender, and diagnosis. It also is necessary to conduct an assessment of acute risk factors which are those psychosocial or symptomatic conditions that may be increasing the patient's risk of suicidal behavior in the short term. Further, the assessment of suicide risk should include consideration of any protective factors that might be reducing the patient's risk of suicide. Synthesizing all of this information, the physician should formulate a medical opinion about the safe management of the patient's suicidal risk, and consider alternatives such as medication adjustments, more frequent follow up, initiation or intensification of psychotherapy, or psychiatric hospitalization in cases of high imminent risk. On or about June 5, 2020, Respondent documented that Patient 3 had experienced suicidal urges, but Respondent did not document a suicide risk assessment or any opinion regarding the patient's suicide risk. Respondent's failure to complete an adequate suicide risk assessment in the context of recent, new onset suicidal ideation or urges in a patient with multiple psychiatric comorbidities constitutes an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts or omissions constituting negligence. The circumstances are set forth in paragraphs 8 through 26, above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

28. The standard of care requires documentation of mental status examination findings in a psychiatric patient, and a list of medications prescribed. The standard of care for a patient receiving controlled substances requires review of the CURES database and documentation that information from CURES formed part of the medical decision-making process. Respondent's failure to document mental status examinations, a medication list, and information from CURES in Patient 1's chart constitutes a departure from the standard of care. Respondent's failure to document mental status examination findings for Patient 2 constitutes a departure from the standard of care at each visit.

29. The standard of care requires that a physician practicing psychiatry perform a complete diagnostic assessment of presenting symptoms; consider differential diagnoses; consider all possible treatments including prescription medication, psychotherapy, behavioral or lifestyle modifications, psychoeducation, referrals to other physicians, and other treatments; and that a treatment plan be communicated to the patient. Respondent failed to comprehensively diagnose and treat insomnia in Patient 1, including forming an opinion as to whether the insomnia was related to major depression, another psychiatric disorder, or other causes, and consideration of and discussion with the patient regarding alternative treatments, even after therapy with controlled substances was unsuccessful. Respondent's failure to comprehensively treat insomnia in Patient 1 constitutes a departure from the standard of care.

30. The standard of care requires use of the lowest effective dose of controlled substances. Respondent prescribed a 30mg dose of temazepam to Patient 1, without documenting any consideration of a lower dosage. 7.5mg and 15mg dosages of temazepam are available. Respondent's failure to consider a lower dosage of temazepam to Patient 1 constitutes a departure from the standard of care.

31. Respondent's failure to document a clinically cogent reason for the unusual addition of eszopiclone to temazepam for Patient 1, and his failure to reassess this therapy despite a lack of benefit, constitutes a departure from the standard of care.

32. Second-generation antipsychotic medications, including Latuda (lurasidone), are known to cause serious metabolic side effects including elevations in blood sugar, elevations in

blood cholesterol, increased appetite and significant weight gain. The standard of care for the use of second-generation anti-psychotics is to conduct periodic laboratory monitoring of blood sugar and blood cholesterol levels. It is also the standard of care to monitor and document changes to the patient's appetite and weight which may be associated with the use of these medications. Respondent's failure to monitor side effects in Patient 2 while prescribing Latuda constitutes a departure from the standard of care.

33. Between on or about June 7, 2019, and on or about June 5, 2020, Respondent failed to document any opinion regarding Patient 3's progress or overall diagnostic status, failed to document a medication reconciliation, and failed to document communication of a treatment plan to the patient. These documentation failures constitute a departure from the standard of care at each visit.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

34. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (d), of the Code, in that he demonstrated incompetence. The circumstances are set forth in paragraphs 8 through 33, above, which are incorporated here by reference. Additional circumstances are as follows:

35. Chronic insomnia is a frequent complaint and practice guidelines have been developed to improve the quality of care provided to patients with that diagnosis. These guidelines emphasize the importance of psychological and behavioral interventions in the treatment of chronic insomnia and indicate that they should be considered first-line relative to psychotropic medication use, particularly long-term psychotropic medication use and polypharmacy. Respondent's failure to document consideration of causation and any nonpharmacological intervention regarding chronic insomnia in Patients 1 and 2 demonstrates incompetence.

36. Respondent's simultaneous prescription of three benzodiazepines to Patient 2, and unawareness of the risk of the combination of opioid and benzodiazepine medications,

demonstrates a lack of knowledge of the risks of respiratory depression and sedation and thus demonstrates incompetence.

FOURTH CAUSE FOR DISCIPLINE

(Recordkeeping)

37. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patients 1, 2, and 3. The circumstances are set forth in paragraphs 8 through 36, above, which are incorporated here by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

38. To determine the degree of discipline, if any, to be imposed on Respondent Dwight William Sievert, M.D., Complainant alleges that on or about October 13, 2016, in a prior disciplinary action titled *In the Matter of the Accusation Against Dwight William Sievert, M.D.* before the Medical Board of California, in Case Number 800-2014-008963, Respondent's license was revoked, with said revocation stayed, and 35 months' probation were imposed with various terms and conditions, related to Respondent's gross negligence in failing to perform an adequate suicide assessment in a psychiatric patient who subsequently committed suicide. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

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

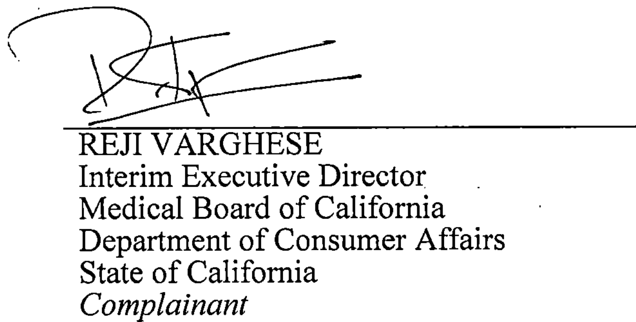
1. Revoking or suspending Physician's and Surgeon's Certificate Number G 47593, issued to Dwight William Sievert, M.D.;

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

3. Ordering Dwight William Sievert, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAY 25 2023



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