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

In the Matter of the Accusation Against: **ENRICO URO BALCOS, M.D.** **1125 E 17th St., Ste. N153** **Santa Ana, CA 92701-2201** **Physician's and Surgeon's Certificate No. A 63363,** Respondent.	Case No. 800-2020-073481 **A C C U S A T I O N**

PARTIES

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

2. On or about August 29, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. A 63363 to Enrico Uro Balcos, 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 December 31, 2024, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California, Department of Consumer Affairs, 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 authorizes the Board to discipline a licensee and obtain probation costs.

5. Section 2228 of the Code authorizes the Board to discipline a licensee by placing them on probation.

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

"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:

"(b) Gross negligence.

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

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

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

7. Section 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."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a

licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

COST RECOVERY

9. 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence during his discharge of patients, as more particularly alleged hereinafter:

11. Respondent, a psychiatrist, treats patients at his private practice, as well as patients at inpatient hospital settings. In approximately April 2020, Respondent began discharging his existing patients[1] at his private practice in order to dedicate more of his time to inpatient treatment. Respondent discharged his patients by sending them termination letters that he would no longer be able to care for his patients and that no new appointments or follow-up appointments were being scheduled. Respondent indicated in the letters that he would only see patients with existing appointments and would also be providing a 90-day prescription for current medications. Absent from the letters were any resources or references where Respondent's patients could locate new providers or mental health services, nor did Respondent facilitate the transfer of care. Additionally, the discharge letters failed to contain directions for obtaining the patients' medical records, or what to do in the case of a crisis or emergency. Finally, the discharge letters were sent

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[1] Respondent's private practice consisted of approximately 50-60 patients in approximately April 2022; Respondent saw his last private patients in approximately July 2020.

via first class mail, not certified, and without any return receipt. As a result, Respondent had no way to verify his patients actually received these letters.

12. In an interview on or about June 23, 2022, Respondent was unable to state exactly how much notice he gave his patients of their discharge and time to find alternative care; only that his patients were given anywhere between 30-90 days of notice. Respondent also indicated that should his patients' new provider seek their medical records, his office would provide them immediately. However, Respondent indicated that he was not even sure that he had a working office phone number at the time of discharging his patients, and the primary means of communication was email.

13. Respondent committed gross negligence which included, but was not limited to, the following:

(a) Respondent inappropriately terminated the physician-patient relationship.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A,[2] as more particularly alleged hereinafter:

15. Patient A, a then 23-year-old female, presented to the emergency department on or about November 3, 2020, with "hallucinations and suicidal statements" according to her boyfriend. Patient A reported being paranoid and tangential, and she admitted to using nitrous oxide. A urine drug screen also tested positive for THC. She had a history of suicide attempts. Patient A's boyfriend reported that Patient A had been using more nitrous oxide than normal, had insomnia, accused him of working for the FBI, and had a plan of cutting herself. Patient A was

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[2] The patient listed in this document is unnamed to protect her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

placed on a 5150 hold[3] for being a danger to herself. She was started on Zyprexa, an antipsychotic medication used to treat mental disorders.

16. Patient A was subsequently transferred to BHC Alhambra Hospital, where she was first evaluated by Respondent on or about November 4, 2020. Patient A confirmed she experienced hallucinations and paranoia. She indicated that she was being prescribed Zyprexa and Depakote (an anticonvulsant used to treat seizure disorders), but was worried about decompensation due to the side effects. Respondent diagnosed Patient A with bipolar disorder, depressed type. He noted that Patient A would be started on medications, but did not document which ones.

17. On or about November 5, 2020, Respondent evaluated Patient A. He noted that Patient A continued to be bizarre and disorganized. Respondent also noted that she required inpatient treatment, but did not note any specific medication prescribed. The following day, Respondent first noted that Patient A was being prescribed Latuda, an antipsychotic used to treat schizophrenia. On or about November 8, 2020, Respondent started lithium (a mood stabilizer used to treat mania), and continued Latuda.

18. On or about November 9, 2020, and November 10, 2020, Respondent did not note any medications following Patient A's evaluation, making it unclear if medications were continued at the same dose, increased, decreased, or discontinued. On or about November 11, 2020, Respondent noted that Patient A was yelling and crying, and she required emergency medications. It was noted that she had failed Abilify (an antipsychotic), but was responsive to Thorazine (an antipsychotic). Respondent also noted that Seroquel (an antipsychotic) would be used to calm her down, along with Lamictal (an anticonvulsant). On or about November 13, 2020, Patient A hit her head on the wall and slammed her fist on the wall. Seroquel was increased and Latuda was maintained.

19. On or about November 14, 2020, November 15, 2020, November 17, 2020, and November 18, 2020, Respondent again did not note any medications that Patient A was being

[3] Welfare and Institutions Code section 5150 allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, herself, or gravely disabled.

prescribed. On or about November 16, 2020, according to the Medication Administration Record, Patient A was started on Depakote; however, Respondent failed to document this medication.

20. On or about November 19, 2020, Respondent noted that Clozaril[4] would be started since other typical and atypical antipsychotics were unsuccessful in controlling Patient A's symptoms, but the dosage was missing. According to the Doctor's Order Sheet, Clozaril was started at 50 mg daily. The Medication Administration Record indicated that dosage was given to Patient A on or about November 20, 2020 and November 21, 2020. The following day, Respondent tripled the dosage of Clozaril to 150 mg daily.

21. On or about November 22, 2020, Respondent noted that Patient A was tearful and wandering aimlessly, and Clozaril would be titrated accordingly, but did not include the dosage of Clozaril. Respondent also noted that Depakote was an appropriate treatment "to prevent any untoward seizures that could be triggered by Clozaril." The following day, after Patient A was wandering impulsively, Respondent noted that "we will continue to titration of Clozaril," yet did not mention any specific doses. He also documented that lithium would be maintained, but did not state the lithium dosage.

22. On or about November 25, 2022, Respondent noted that he intended to titrate Clozaril between 200-300 mg per day. On or about November 27, 2020, Patient A had an unwitnessed fall. There was a physician note dated "10/27/20" that indicated Patient A had "psychomotor retardation," but the end of the note was dated "11/28/20." The note also indicated that Clozaril would be titrated further, but did not mention a specific dose.

23. On or about November 28, 2020, Patient A reported chest pain and was transferred to the San Gabriel Emergency Department. According to Respondent's discharge summary on the same date, Patient A was noted to have an altered mental state and sent to the emergency department. Patient A was initially taken to Greater El Monte Community Hospital, where she

[4] Clozaril (clozapine) is an antipsychotic medication used to treat severely ill patients with treatment-resistant schizophrenia. According to the Black Box Warning Label, seizures have been associated with the use of Clozaril and dose appears to be an important predictor of seizure, with a greater likelihood of seizures at higher doses. It is recommended to start Clozaril at 12.5 to 25 mg daily, and the dosage can be increased in increments of 25-50 mg daily.

was diagnosed with a new onset seizure, then transferred to San Gabriel Hospital. The emergency department at San Gabriel Hospital noted that her presentation may have been due to a side effect from Clozaril or from psychosis due to nitrates. A follow-up physician note from a different provider on or about December 9, 2020, indicated that Patient A "had a Clozaril vs. Ativan withdrawal vs. nitrous oxide induced seizure."

24. Respondent committed repeated acts of negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent prescribed Clozaril without appropriate dose titration;

(b) Respondent failed to adequately document medication reconciliation that included an accurate, up-to-date medication list for each physician note.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

25. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 14 through 24, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 63363, issued to Enrico Uro Balcos, M.D.;

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

3. Ordering Enrico Uro Balcos, 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

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

DATED: DEC 23 2022

Reji Varghese
Deputy Director

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

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