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

In the Matter of the Accusation Against: Arakel Davtian, M.D. Physician's and Surgeon's Certificate No. A 53402 Respondent.	Case No.: 800-2021-076360

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 May 27, 2025.

IT IS SO ORDERED: April 25, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D. , Chair
Panel A

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

In the Matter of the Accusation Against: **ARAKEL DAVTIAN, M.D.** **1016 Old Phillips Road** **Glendale, CA 91207-1110** **Physician's and Surgeon's Certificate No. A 53402,** Respondent.	Case No. 800-2021-076360 OAH No. 2024080130 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Christine Friar Walton, Deputy Attorney General.

2. Respondent Arakel Davtian, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon of Doyle Schafer McMahon, LLP, located at 5440 Trabuco Road, Irvine, California 92620.

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3. On or about August 17, 1994, the Board issued Physician's and Surgeon's Certificate No. A 53402 to Respondent. That Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-076360, and will expire on January 31, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076360 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 18, 2024. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2021-076360 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-076360. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-076360, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* case for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-2021-076360, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 53402 to disciplinary action.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-076360 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any

other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 53402 issued to Respondent Arakel Davtian, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing

practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this

Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure

that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

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

6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants. Respondent is further prohibited from supervising any advanced practice nurses, provided that notwithstanding anything to the contrary contained herein, Respondent may continue to supervise

the advanced practice nurse that was under his supervision at the time of his execution of this Stipulated Settlement.

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

8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $50,854.31 (Fifty thousand eight hundred and fifty-four dollars and thirty-one cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no

circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-

practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

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

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have

continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-076360 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 2/9/2025

Arakel Davtian
ARAKEL DAVTIAN, M.D.
Respondent

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

DATED: February 10, 2025

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

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

DATED: February 10, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

Christine Friar Walton

CHRISTINE FRIAR WALTON
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2021-076360

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

In the Matter of the Accusation Against: **Arakel Davtian, M.D.** **1016 Old Phillips Road** **Glendale, CA 91207-1110** **Physician's and Surgeon's Certificate No. A 53402,** Respondent.	Case No. 800-2021-076360 **ACCUSATION**

PARTIES

1. Reji Varghese (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 17, 1994, the Board issued Physician's and Surgeon's Certificate Number A 53402 to Arakel Davtian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2026, unless renewed.

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 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

7. 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.
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> (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.
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> (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.
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> (f) Any action or conduct that would have warranted the denial of a certificate.
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> . . . .

8. 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.

9. Section 2228.1 of the Code states.

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length

of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

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(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

COST RECOVERY

10. 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.

DRUG DEFINITIONS

11. As used herein, the terms below will have the following meanings:

Alprazolam (brand name: Xanax), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders.

"Beers Criteria" is the American Geriatrics Society's Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, which is a list of medications that healthcare providers reference to safely prescribe medications for people above age 65.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Commonly prescribed benzodiazepines include alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin), diazepam (Valium), and temazepam (Restoril). Risks

associated with use of benzodiazepines include: 1) tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Before initiating a course of treatment, patients should be explicitly advised about the following: the goal and duration of benzodiazepine use; its risks and side effects, including risk of dependence and respiratory depression; and alternative treatment options. In general, benzodiazepines are considered high-risk medications in the elderly and are identified in the Beers Criteria as potentially inappropriate medications to be avoided in patients sixty-five (65) years and older due to risk of abuse, misuse, physical dependence, and addiction, as well as risks of impaired cognition, delirium, falls, fractures, and motor vehicle accidents with benzodiazepine use.

Clonazepam (brand name: Klonopin), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.

Mirtazapine (brand name: Remeron), an antidepressant, is a medication primarily used to treat depression, and is a dangerous drug pursuant to Code section 4022. It is often used to treat depression complicated by anxiety or trouble sleeping.

Quetiapine (brand name: Seroquel), an atypical antipsychotic drug, is a medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder, and is a dangerous drug pursuant to Code section 4022.

Sertraline (Zoloft), an antidepressant and a selective serotonin reuptake inhibitors (SSRI), is a medication commonly used to treat depression, anxiety, panic attacks and other mood disorders. It is a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent, a psychiatrist, 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 in connection with his care and treatment of Patients A, B, and C,[1] as more fully alleged as follows:

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[1] The patients' actual names are not used in this Accusation to maintain patient confidentiality. The patient identities are known to Respondent and will be disclosed to Respondent upon a duly issued request for discovery in accordance with Government Code section 11507.6.

Patient A

13. On or about January 26, 2018, Respondent examined Patient A, a then 83-year old female, while she was in an assisted living facility (ALF).[2] Respondent's single-page typewritten Psychiatry Progress Note, in a standard SOAP (subjective, objective, assessment, plan) format, includes[3] a "Subjective: Patient's Complaints" section stating, "I feel hopeless, I don't have any interests. I get more anxious at evenings." Boxes are checked for "Sadness" and "Anxiety" with a notation that Patient A's "behaviors [are] well controlled with current medications," which are listed as mirtazapine (Remeron) 30 mg every evening and 15 mg every morning for depression; and quetiapine (Seroquel) 50 mg every morning and before sleep as ordered by PCP (primary care physician); and clonazepam (Klonopin)[4] 0.5 mg twice a day as needed for severe anxiety and panic attacks. Other recommendations included a behavioral management program and non-pharmacological interventions provided as needed; and continue Aricept 10 mg as ordered by the PCP for cognitive decline. Positive objective findings included moderately impaired judgment/insight, short term memory deficit, and immediate recall moderately impaired. Past medications are noted as beneficial. A box is checked for plans of treatment and side effect discussed with no further details. Respondent's assessment included severe depression and generalized anxiety disorder and his plan included keeping Patient A on her current medications.

14. Beginning on or about January 26, 2018, through December 11, 2020, Respondent had eleven additional patient encounters with Patient A, which were all documented on his single-page typewritten form, each with the title, "Psychiatric Progress Notes." In general, Respondent's Psychiatric Progress Notes for the eleven visits are essentially the same with the

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[2] The ALF certified medical records contained one earlier Psychiatric Progress Note which documented an encounter with Respondent on or about October 27, 2015.

[3] As used herein, "includes" or "including" means "includes, without limitation" or "including, without limitation."

[4] The California Controlled Substance Utilization Review and Evaluation System (CURES) report for May 2018 to May 2021, indicates that Respondent prescribed Patient A sixty (60) 0.5 mg pills of clonazepam on a near monthly basis during this period of time. CURES is California's prescription drug monitoring program which tracks Schedule II, Schedule III, Schedule IV, and Schedule V controlled substance prescriptions dispensed in California.

exception of one or two different sentences in the "Subjective: Patient Complaints" section.[5] Throughout this period of time, Patient A's medication regimen remained the same.

15. Respondent committed gross negligence with regard to his medical record documentation for Patient A while she was at the ALF. There is a lack of adequate documentation of informed consent for the specific medications prescribed to Patient A. There is also a lack of adequate documentation of compliance monitoring, including a lack of laboratory monitoring and a lack of any acknowledgment of having reviewed any bloodwork ordered by another provider. The only discussion around interval history is in the "Subjective: Patient Complaints" section and it is limited to one or two sentences. Many of Respondent's chart notes are so similar it is difficult to ascertain any changes in the interval between patient visits. The Psychiatric Progress Notes reflect a lack of attention and care with respect to psychological issues, psychiatric medications and medical issues that may impact the patient. When a specific issue is mentioned, such as the insomnia in the note dated February 23, 2020, there is no consideration of behavioral interventions or medications to address the insomnia issues, or discussion of psychosocial interventions for complaints such as "I have no interests" in the chart note dated February 4, 2019. There is no discussion of the risks and benefits of tapering medications given Patient A's overall stability. Some parts of a standard evaluation, such as evaluation of appetite, are not noted at all. There is no discussion of Patient A's medical issues and how they could interact with her psychiatric presentation. The records also fail to adequately convey a sense of evaluation of Patient A and her situation, or clear reasons for the treatment paths chosen.

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[5] Specifically, the different subjective complaints were: "I feel hopeless, I don't have any interest. I get more anxious at evenings." (note dated January 26, 2018); "I just want to be left alone. I don't want to talk to people." (note dated April 24, 2018); "I am feeling less depressed now but my anxiety is the problem." (note dated September 9, 2018); "I am so lonely, nothing is going on [in] my life." (note dated November 17, 2018); I feel so depressed and helpless. I have no interests." (note dated February 4, 2019); "I feel hopeless, I don't get better." (note dated June 22, 2019); "I feel so so, nothing is changing in my life, I don't want to talk to people here." (note dated November 6, 2019); "I'm feel [sic] sad and anxious. I am tired during the day but I cannot sleep." (note dated February 23, 2020); "I'm not doing well. I lost my hope that I will get better." (note dated May 22, 2020); "I am doing okay now, I am feeling anxious as usual." (note dated September 12, 2020); and "I am anxious, I want to get up but I don't have the energy." (note dated December 11, 2020).

16. Respondent committed gross negligence with regard to his prescribing of quetiapine (Seroquel) to Patient A while at the ALF, including inadequate informed consent and monitoring pertaining to quetiapine (Seroquel). There were no attempted trials of other medications to manage Patient A's symptoms despite Patient A's primary diagnosis of dementia, Alzheimer's type, psychosis, but instead there are repeated statements that Patient A was stable and that it was contraindicated to lower the dose, despite documentation stating there were no perceptual disturbances or delusions. Given the risks of antipsychotics in the elderly[6], an attempt to reduce medication or try alternatives for behavioral control should have been made. There was no lab work, tardive dyskinesia screening, or other monitoring of metabolic side effects in this patient.

Patient B

17. On or about July 6, 2018, Respondent examined Patient B, a then-61-year old female. Respondent's typewritten progress note, in a standard SOAP format, included a template with a "Complaint(s) / HPI" section stating, "I am very anxious and stay home most of the time." There is a "Subjective" section with boxes checked for anxiety and sadness. The progress note contains other sections for allergies, social history, past medical history, family history, objective, and physical exam, which are all blank. The "Assessment" section has a box checked for "Stable; diagnosis." The "Diagnosis Codes" section lists F411 Generalized Anxiety Disorder and the "Procedure Codes" section lists a medication management code. No boxes are checked in the "Plan" section. In the Plan section, a box stating, "Plans of treatment and side effects of medication discussed with patient" is checked (even though medications are listed as zero) and no lab work is checked. The "Follow Up Plan" section states that a follow up visit is suggested after three months. Lastly, there is an Addendum dated August 23, 2021 (over three years later) which sets forth "continue with the current medications" followed by Sertaline 25 mg every morning, alprazolam (Xanax) 0.25 mg twice a day as needed; and mirtazapine (Remeron) 15 mg before sleep.

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[6] Quetiapine (Seroquel) had a black box warning which stated, "Elderly patients with dementia related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine is not approved for the treatment of patients with dementia-related psychosis."

18. On or about September 11, 2018, through June 4, 2021, Respondent had ten more encounters with Patient B, all documented on his two to three pages of typewritten progress notes identical in format to the note described above.[7] The "Complaint(s) / HPI" section of each progress note is minimal with one to two sentences of information, except for the note dated June 5, 2021, which is four sentences long.[8] The Subjective section has boxes checked often for anxiety, sadness, and poor concentration with "Past Meds Beneficial." Speech is variable,, marked as pressured, selectively mute, or verbose, and constricted affect is occasionally noted. "Denies current self-harm or assaultive thoughts" is checked in the most recent two notes. The progress note sections for allergies, social history, past medical history, family history, objective, and physical exam are all blank. The diagnosis set forth is each progress note is generalized anxiety disorder. In the Plan section, a box stating, "Plans of treatment and side effects of medication discussed with patient" is checked on all of the notes (even though some medications are listed after the fact through addendum and some notes list no medications), and no lab work is checked. Medications are sometimes listed in this section without quantities dispensed, and the benzodiazepines are never noted. Several notes contain an Addendum Section dated August 23, 2021, with these medications noted and some additional medication information.[9]

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[7] The sections of the template are Complaint, Allergies, Social History, Past Medical History, Surgical History, Family, History, Objective, Physical Exam, Assessment, Diagnostic Codes, Procedure Codes, and Plan.

[8] Specifically, the different subjective complaints were: "I am not feeling well, still having anxiety." (note dated September 11, 2018); "I am doing okay with my medications and feeling little bit better." (note dated January 8, 2019); "The patient is doing okay and want[s] to continue." (note dated July 10, 2019); I am doing okay with my meds." (note dated October 10, 2019); "I am very anxious and very confused. I cry all day long." (note dated November 19, 2019); I am crying a lot, and having a [sic] little depressed." (note dated July 10, 2020); I am crying again. And I need my medication." (note dated September 18, 2020); "I am having anxiety again." (note dated October 23, 2020); I am taking my medication every day, and I am able to sleep 7-8 hours a day." (note dated February 21, 2021); and "I am here for my follow up. My sleeping pattern is getting better and I am able to eat more. I still feel fatigue and have poor concentration sometimes. I try to take less clonazepam." (note dated June 4, 2021).

[9] Combining information from the addendums and the body of the progress notes, Patient B is on Sertraline 25 mg, Alprazolam 0.25 mg twice a day as needed, and mirtazapine (Remeron) 15 mg before sleep (July 6, 2018); the Alprazolam and mirtazapine are noted to be continued but there is no notation regarding the Sertraline (September 11, 2018) which are both presumably continued until November 2019 when an addendum notes alprazolam (Xanax) is being tapered and clonazepam 1 mg twice a day (as needed) is prescribed (November 11, 2019); in September

19. Respondent committed gross negligence with regard to his medical record documentation for Patient B. There is a lack of adequate documentation of an informed consent for the specific medications he prescribed to Patient B, despite several new medications being initiated during the interval reviewed. There is also a lack of adequate documentation of compliance monitoring, including a lack of laboratory results or notes from other providers. His records also lack pharmacy paperwork/records. Pertinent matters regarding the patient were not documented.[10] The only discussion around interval history is in the "Complaint" section which is generally limited to one or two sentences. When a specific issue is mentioned, such as staying home most of the time, there is no documentation of addressing this psychosocial issue. When confusion is mentioned, there is no consideration of behavioral interventions or medication changes to address it. The controlled substances and some of the other medications prescribed are not noted in most of the original notes and only added after the fact in an addendum, so this information would not have been available if needed in the time period covered by the notes. Many parts of a standard evaluation, such as evaluation of sleep, appetite, thought process, or thought content are not noted at all or the template is empty (sleep and appetite are noted only in the last note of the interval). There is no discussion of the patient's medical issues or outside medications and how they could interact with her psychiatric presentation. In summary, Respondent's medical records for Patient B fail to adequately convey Patient B's medical presentation and his rationale for the treatment.

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2020 the note continues the mirtazapine, and addendums confirm clonazepam is also continued and notes a trial of Seroquel 25 mg twice a day "for sadness" (September 18, 2020); quetiapine (Seroquel) is discontinued and Cymbalta is started (October 23, 2020); and in February of 2021 the Cymbalta is stopped with the addendum noting "not effective, did not take it." (February 12, 2021).

[10] Respondent appeared for a subject interview before a Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU) investigator. During the subject interview, Respondent stated Patient B would call or visit his office every week; she believed she was being poisoned by her daughter; she ruminated about a shoplifting incident; she began to believe she was being sued and could not be convinced otherwise; and that her daughter would also call his office. None of this was documented in the certified medical records.

Patient C

20. On or about January 23, 2020, Respondent examined Patient C, a then-60-year old male, with a complicated medical history.[11] Respondent's typewritten progress note, in a standard SOAP format, includes a template with a "Complaint(s) / HPI" section stating, "I am feeling good and these medication is [sic] helping me." The "Subjective" section includes checked boxes for anxiety and poor concentration with past medications noted to be beneficial. The patient's social history includes being a "non-smoker," who consumes "no alcohol," and uses "no street drugs." The progress note also contains sections for past medical history, surgical history, family history, objective, and physical exam, which are all blank. The "Assessment" section indicates "r/o [rule out] depression/anxiety," with a box checked for spectrum (severe). The "Diagnosis Codes" section documents an F332 code for Major Depressive Disorder, recurrent, severe, without psychotic features. The "Plan" section lists medications which include Pexeva Mesylate 20 mg, one tab every morning, and Seroquel 100 mg 1 tab daily; there is a box checked stating, "Plans of treatment and side effects of medication discussed with patient," and the box for lab work is not checked. The "Follow Up Plan" section of the progress note states that a follow up visit is suggested after three months.

21. Beginning on or about May 22, 2020, through October 8, 2021, Respondent had four more encounters with Patient C, all documented on his two pages of typewritten progress note form which is identical in format to the progress note described above. The "Complaint(s)/HPI" section of each progress note is minimal with one to two sentences of information.[12] The Subjective section has various boxes checked during this timeframe for patient complaints of

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[11] A Progress Note from UCLA Health dated May 5, 2021, lists the patient's chronic problems, including HIV, anal cancer, vitamin D deficiency, HSV [herpes simplex virus]-chronic infection, latent TB [tuberculosis], history of stroke, erectile dysfunction, major depressive disorder, hyperlipidemia, overweight, CKD [chronic kidney disease] Stage 2, history of onycomycosis, and folate deficiency anemia.

[12] Specifically, the different subjective complaints were: "I am doing good." (note dated May 22, 2020); I am doing [sic] feeling all right." (note dated January 15, 2021); "He feels irritable and doesn't have any good social contacts. He cannot get along with his family members, always having fight." (note dated July 16, 2021); and [Patient] complain[s] of fatigue and loss of interest to do thing[s]. He stays home and do[es] feel [sic] want to go out and talk to people." (note dated October 8, 2021).

insomnia, anxiety, sadness, and/or poor concentration; selectively mute speech; some controlling behavior; anxious, sad, and/or irritable mood; and shallow or constricted affect; with a notation of "Past Meds Beneficial." The progress note sections for past medical history, surgical history, family history, objective, and physical exam, are all blank. Patient A's medications remained the same during this timeframe. The box for "Plans of treatment and side effects of medication discussed with patient" is blank for the progress note dated January 15, 2021.

22. Respondent committed gross negligence in connection with his medical record documentation for Patient C. There is a lack of adequate documentation of an informed consent for the specific medications he prescribed to Patient C. There is also a lack of adequate documentation of compliance monitoring, including a lack of laboratory results or notes from other providers. His records also lack pharmacy paperwork/records. The only discussion around interval history is in the "Complaint" section and is limited to one or two sentences. There is no mention of past substance use, of supported housing, or past hospitalizations and rehab. There is no discussion of ongoing recovery or sobriety efforts beyond the notation that he is not using substances. When a specific issue is mentioned, such as in his chart note dated July 16, 2021, where it is noted Patient C is not getting along with family members, there is no documentation of addressing this psychosocial issue. When insomnia is checked in a checkbox, there is no consideration of behavioral interventions or medication changes to address it. There is no discussion of the risks or benefits of tapering medications given the patient's overall stability. Some parts of a standard evaluation, such as evaluation of appetite, are not noted at all. There is no discussion of the patient's medical issues and how they could interact with his psychiatric presentation. The diagnosis is limited and at times contradictory with no mention of the substance use diagnosis. In summary, Respondent's medical records for Patient C fail to adequately convey Patient C's medical presentation.

23. Respondent committed gross negligence as to Patient C in regard to his psychiatric medication management. Throughout the interval reviewed, Respondent prescribed Pexeva (20 mg) and Seroquel (100 mg) daily to Patient C for his depressive disorder which was noted at times to have psychotic features. Seroquel is an antipsychotic medication that requires ongoing

metabolic monitoring. There is also a lack of adequate documentation of compliance monitoring, including a lack of orders by Respondent for bloodwork for monitoring. He also failed to adequately coordinate care with Patient C's primary care physician to get bloodwork done. Monitoring and discussions of the risks and benefits of Patient C's current treatment were necessary given Patient C's age and his concurrent medical problems.

24. Respondent committed negligence as to Patient C in regard to his medical monitoring and coordination of care. Respondent did not note or consider the patient's multiple medical issues which could affect the patient's psychiatric presentation; nor was there any coordination of care regarding the patient's treatment for his physical issues and his psychiatric care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2334, subdivision (c), of the Code, in that he committed repeated negligent acts in connection with his care and treatment of Patients A, B, and C, as more particularly alleged herein.

Patient A

26. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth herein. The acts and/or omissions by Respondent set forth in the First Cause for Discipline with respect to Patient A, either collectively or in any combination thereof, constitute repeated negligent acts, as discussed more fully herein.

27. Respondent committed negligence in connection with his inadequate medical monitoring and coordination of care as to Patient A, and/or failure to adequately document the same. In light of Patient A's presentation to Respondent, including her use of controlled substances, Respondent failed to adequately coordinate and monitor her to ensure patient safety. Patient A had been diagnosed with Vitamin D deficiency and hyperlipidemia and was taking Vitamin D. She also suffered from chronic kidney disease. Vitamin D deficiency could affect mood and psychiatric symptoms. Further, her antipsychotic medications could worsen her hyperlipidemia. Chronic kidney disease is also important to acknowledge and follow as it can

affect the metabolism and elimination of many medications. However, Respondent's poor documentation fails to adequately reflect the requisite coordination of care and attention to these issues. Patient A also came from the emergency room to the skilled nursing facility with a multiple list of medical issues. However, over the time period he cared for Patient A, Respondent failed to adequately follow up with these issues. Gathering her past medical information would be essential to the overall care of Patient A.

28. Respondent committed negligence in connection with his prescribing and treatment of Patient A with controlled substances during her stay at the ALF, including clonazepam. Respondent failed to adequately attempt to taper Patient A's medication or try other alternatives, failed to adequately monitor Patient A's use of the medication, and failed to adequately coordinate her care. Treatment trials, alternatives, and tapering were not adequately performed and/or documented in light of Patient A's age and treatment with benzodiazepines.

Patient B

29. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth herein. The acts and/or omissions by Respondent set forth in the First Cause for Discipline with respect to Patient B, either collectively or in any combination thereof, constitute repeated negligent acts, as discussed more fully herein.

30. Respondent committed negligence as to Patient B with regard to his lack of medical monitoring and coordination of care. Respondent's psychiatric records do not address concurrent medical issues, or show any coordination with a medical provider or awareness of medical monitoring such as laboratory results. Vital signs are only noted on a single visit. A review of Patient B's CURES records shows two prescriptions by outside doctors for controlled substances, neither of which are prescribed on an ongoing basis, but which could have interactions with Respondent's ongoing benzodiazepine prescriptions. Pharmacy records also show the patient was on non-controlled medications which could have directly affected the patient's psychiatric status or were indicative of other medical diagnoses that could affect the patient's psychiatric presentation. For example, gabapentin could help alleviate anxiety and coordinating dosing with the outside provider could have potentially led to increased control of her symptoms with less

reliance on benzodiazepines. Meclizine (which should be avoided in the elderly) is usually prescribed for dizziness, which could have been a part of Patient B's anxiety presentation and possibly avoided by better coordination with the outside prescriber, considering that it can also cause drowsiness and memory impairment and could have contributed to her complaint of being confused. Patient B was prescribed Vitamin D3, and Vitamin D deficiency can cause symptoms of depression. Finally, atenolol can cause depression and sometimes is used to treat certain aspects of anxiety. These medications could directly affect the patient's psychiatric status and should have been addressed through coordination of care with her other health care provider(s). These issues were not adequately addressed during Respondent's care and treatment of Patient B.

31. Respondent committed negligence as to Patient B with regard to his psychiatric medication management. Respondent prescribed Seroquel to Patient B in or around September 2020. Seroquel is an antipsychotic medication that requires initial and ongoing metabolic monitoring. Respondent did not order bloodwork to monitor Patient B's use of that drug. He also failed to coordinate with the primary care physician with respect to her bloodwork. Respondent failed to adequately monitor and discuss the risks and benefits of treatment with Patient B in connection with her psychiatric medications especially in light of the fact that Patient B is older, with concurrent medical problems, and was noted to be overweight. Respondent stated during his subject interview with Board representatives that Patient B's symptoms included paranoia, which was documented in her medical chart and may have contributed to his decision making in this regard, but his use of Seroquel "for sadness" as noted in his Addendum, is not standard first line treatment.

Patient C

32. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth herein. The acts and/or omissions by Respondent set forth in the First Cause for Discipline with respect to Patient C, either collectively or in any combination thereof, constitute repeated negligent acts.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

33. Respondent is further subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to patients as discussed more fully in the First and Second Causes for Discipline which are incorporated by reference as if 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 Number A 53402, issued to Respondent Arakel Davtian, M.D.;

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

3. Ordering Respondent Arakel Davtian, 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;

4. Ordering Respondent Arakel Davtian, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: MAR 18 2024

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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