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

In the Matter of the Accusation Against: **MARK HAMILTON HENIGAN, D.O.** **930 Alhambra Blvd., Suite 280** **Sacramento, CA 95816-4479** **Osteopathic Physician's and Surgeon's Certificate No. 20A 6351** Respondent	Case No. 900-2019-000221 OAH No. 2022010530

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on 09/16/2022.

It is so ORDERED 08/16/2022.

CYRUS BUHARI, D.O., PRESIDENT
FOR THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **MARK HAMILTON HENIGAN, D.O.** 930 Alhambra Blvd., Ste 280 Sacramento. CA 95816-4479 Osteopathic Physician's and Surgeon's Certificate No. 20A 6351 Respondent.	Case No. 900-2019-000221 OAH No. 2022010530 **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. Mark M. Ito ("Complainant") is the Executive Director of the Osteopathic 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 John S. Gatschet, Deputy Attorney General.

///

2. Respondent Mark Hamilton Henigan, D.O. ("Respondent") is represented in this proceeding by attorney Bruce E. Salenko, Esq., whose address is:

Bruce E. Salenko, Esq.
Low McKinley Baleria & Salenko LLP
2150 River Plaza Drive, Suite 250
Sacramento, CA 95833

3. On or about October 5, 1992, the Board issued Osteopathic Physician's and Surgeon's Certificate No. 20A 6351 to Mark Hamilton Henigan, D.O. (Respondent). The Osteopathic Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 900-2019-000221, and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 900-2019-000221 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 December 8, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 900-2019-000221 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 900-2019-000221. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 900-2019-000221, if proven at a hearing, constitute cause for imposing discipline upon his Osteopathic Physician's and Surgeon's Certificate.

10. 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.

11. ACKNOWLEDGMENT. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2459.4, serves to protect the public interest.

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

CONTINGENCY

13. This stipulation shall be subject to approval by the Osteopathic Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Osteopathic 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.

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. 900-2019-000221 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 Osteopathic Physician's and Surgeon's Certificate No. 20A 6351 issued to Respondent Mark Hamilton Henigan, D.O. is revoked. However, the revocations are stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. **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.

2. **Patient Disclosure (Bus. & Prof. Code § 2459.4).** Before a patient's first visit following the effective date of this order and while the respondent is on probation, the respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the respondent's probation on the respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure 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 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) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

3. **Quarterly Reports.** Respondent shall submit to the Board quarterly declaration under penalty of perjury on the Quarterly Report of Compliance Form, OMB 10 (1/18) which is hereby incorporated by reference, declaring under penalty of perjury whether there has been compliance with all the conditions of probation.

4. **Probation Surveillance Program.** Respondent shall comply with the Board's probation surveillance program. Respondent shall, at all times, keep the Board informed of his addresses of business and residence, which shall both serve as addresses of record for purposes of service of process while Respondent is on probation. Changes of such addresses shall be immediately communicated in writing to the Board. A post office box address shall not be permitted to serve as an address of record.

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

5. **Interviews with Medical Consultants.** Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

6. **Cost Recovery.** The Respondent is hereby ordered to reimburse the Board the amount of **$29,060.00** within 90 days from the effective date of this decision for its investigative and prosecution costs, unless the Board and Respondent agree to a payment plan. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship. The Board agrees and understands that Respondent requires a payment plan to pay cost recovery in this matter.

7. **License Surrender.** Following the effective date of this decision, if Respondent

ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, the Respondent may voluntarily tender his certificate to the Board. The Board reserves the right to evaluate the Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no longer be subject to the terms and conditions of probation.

8. **Tolling for Out-of-State Practice or Residence, or In-State Non-Practice (Inactive License).** In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the board or its designee in writing within ten (10) calendar days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in Section 2051 and/or 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will extend the probationary period by the period of out-of-state residence or non-practice. Respondent's period of non-practice while on probation shall not exceed two (2) years. If Respondent's non-practice exceeds two years, the Respondent shall be considered in violation of his probation terms.

9. **Probation Violation/Completion of Probation.** If Respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving Respondent notice and the opportunity to be heard. If an Accusation and/or Petition to revoke is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be automatically extended until the matter is final. Respondent shall comply with all financial obligations (e.g., cost recovery) no later than 60 calendar days prior to the completion of probation. If Respondent fails to comply with all financial obligations, the Board shall consider the Respondent in violation of

probation. Upon successful completion of probation, Respondent's certificate will be fully restored.

10. **Notification to Board of Employers; Notification to Employers of Discipline.** Respondent shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers, and supervisors and shall give specific written consent that the licensee authorizes the Board and the employers and/or supervisors to communicate regarding the licensee's work status, performance, and monitoring on probation.

Respondent shall notify any employer of the terms of this probation by providing a copy of this decision to each and every employer within 30 calendar days of this effective date of the decision, asking each employer to acknowledge receipt in writing, and submitting such acknowledgment to the Board.

11. **Supervision of Physician Assistants and Advanced Practice Nurses.** During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

12. **Controlled Drugs - Partial Restriction.** Respondent is permitted to prescribe, administer, dispense or order controlled substances listed in Schedule(s) IV and V of the California Uniform Controlled Substance Act while on probation. Respondent is **not permitted** to prescribe, administer, or order controlled substances listed in Schedule II and III of the California Uniform Controlled Substances Act while on probation.

As the sole exception to the Board's restriction of Respondent's Schedule II's prescribing privileges, the Respondent shall be allowed to prescribe controlled substances specifically listed in Health and Safety Code section 11055, subdivision (d), entitled "Stimulants," to his patients for the treatment of his patients' bona fide illnesses and/or conditions. Respondent's prescription of stimulants listed in Health and Safety Code section 11055, subdivision (d), shall be reviewed by the staff of the Professional Enhancement Program as set forth in Probation Condition 17 to ensure Respondent's compliance with the applicable standard of care.

13. **Controlled Drugs - Maintain Record.** Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by Respondent during probation,

showing all the following: (1) the name and address of the patient, (2) the date, (3) the character and quantity of controlled substances involved and (4) the pathology and purpose for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Board or its designee, upon request.

14. **Pharmacology Course.** Within 60 days of the effective date of this decision, Respondent shall enroll in a course in Pharmacology/Prescribing practices course equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine ("Program"), approved in advance by the Board or its designee. Respondent shall provide the Program with any information and documents that the program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no 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/pharmacology course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirement 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.

Respondent shall submit written evidence of successful completion of the course to the Board within fifteen (15) calendar days after successful completion.

15. **Education Course.** Within 90 days of the effective date of this decision, and on an annual basis thereafter, Respondent shall submit to the Board for its prior approval 18 hours of educational programming and/or coursework related to correcting the violations and deficiencies charged in the Accusation. The Respondent shall complete this additional CME coursework each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Board or its designee

may administer an examination to test the Respondent's knowledge of the course. Respondent shall provide proof of attendance for both Respondent's continuing medical education requirements and the educational coursework that this probation condition requires on a yearly basis to the Board

16. **Record Keeping Course.** Within 60 calendar days of the effective date of this decision, respondent shall submit to the Board for its prior approval a course in record keeping which respondent shall successfully complete during the first year of probation. All courses shall be at the respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A 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 the condition if the course would have been approved by the Board.

Respondent shall submit written evidence of successful completion of the course to the Board with fifteen (15) calendar days after successful completion.

17. **Clinical Training Program.** Within 90 calendar days of the effective date of this decision, the Respondent shall submit to the Board for its prior approval, an intensive clinical assessment and training program equivalent to the Affiliated Monitor's Incorporated's Clinical Assessment. The exact number of hours and the specific content of the program shall be determined by the Board or its designee and shall be related to the violations charged in the Accusation. Respondent shall successfully complete the program within six (6) months from the date of enrollment and may be required to pass an examination administered by the Board or its designee related to the program's contents.

The program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health, basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to the area of practice to which the violation(s) related and, at a minimum, a 40 hour program of clinical education in the area of practice to which the violations related and that takes into account the

assessment, decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the program.

Based upon respondent's performance and test results in the assessment and clinical education, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional education or training, treatment needed for any medical or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the recommendations of the program.

The Board may immediately order respondent to cease the practice of medicine without a hearing if the respondent should fail to enroll, participate in, or successfully complete the program within the time specified. The respondent may not resume the practice of medicine until enrollment or participation in the program is complete.

Respondent shall submit written evidence of successful completion of the program to the Board within fifteen (15) calendar days after successful completion.

Professional Enhancement Program (In Lieu of Practice Monitor).

Within 60 calendar days after the Respondent has successfully completed the clinical assessment and training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Affiliated Monitors, Incorporated's Independent Compliance Monitoring Program, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in such professional enhancement program at the respondent's own expense during the term of probation, or until the Board, or its designee, determines that further participation is no longer necessary.

18. **Physical Health Evaluation (Sleep Apnea).** Within 30 calendar days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a physical health evaluation, specifically tailored to the evaluation of Respondent's sleep apnea condition, by a Board appointed physician who shall furnish a medical report to the Board or its designee. The Board hereby agrees that the Board appointed physician may include the Respondent's current treating physician for sleep apnea and shall approve that physician for this evaluation should Respondent choose to use his current

physcian. Respondent shall pay all costs of the physical health evaluation. The Board appointed physician shall provide to the Board, at a minimum, a report that explains the Respondent's sleep apnea condition, his current prognosis, his future prognosis, what medical treatments he is currently receiving, and whether or not he is safe to practice medicine. If the evaluating physician feels that Respondent is not safe to practice, the evaluating physician shall notify the Board. Failure to successfully complete a physical health evaluation shall be a violation of probation and grounds for the issuance of a Cease Practice Order.

19. **Medical Treatment (Sleep Apnea).** Within 60 calendar days of this decision, respondent shall submit to the Board for its prior approval the name and qualifications of physician of respondent's choice. Upon approval, respondent shall undergo and continue until the Board deems that no further medical treatment for sleep apnea is necessary. Respondent shall have the treating physician submit quarterly status reports of the periodic medical evaluations. Respondent shall pay the costs of such medical treatments. Respondent shall comply with any treatment recommended by the physician that the physician determines is required to ensure that respondent may continue to practice safely.

20. **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. 900-2019-000221 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 a license.

///

///

///

///

///

///

///

///

///

///

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Bruce E. Salenko, Esq.. I understand the stipulation and the effect it will have on my Osteopathic 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 Osteopathic Medical Board of California.

DATED: 26 May 2022

MARK HAMILTON HENIGAN, D.O.
Respondent

I have read and fully discussed with Respondent Mark Hamilton Henigan, D.O. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5/31/22

BRUCE E. SALENKO, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: June 2, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

SA2021304436
36100845.docx

Exhibit A

Accusation No. 900-2019-000221

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Mark Hamilton Henigan, D.O.** 930 Alhambra Blvd., Ste 280 Sacramento. CA 95816-4479 Osteopathic Physician's and Surgeon's Certificate No. 20A 6351, Respondent.	Case No. 900-2019-000221 **ACCUSATION**

PARTIES

1. Mark M. Ito ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about October 5, 1992, the Osteopathic Medical Board of California issued Osteopathic Physician's and Surgeon's Certificate Number 20A 6351 to Mark Hamilton Henigan, D.O. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, 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 3600 of the Code states, in pertinent part:

> The law governing licentiates of the Osteopathic Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to the practice of medicine.

5. Section 2450 of the Code states, in pertinent part:

> There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter related to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.
>
> ...

6. Section 2450.1 of the Code states, in pertinent part:

> Protection of the public shall be the highest priority of the Osteopathic Medical Board of California exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with the interests sought to be promoted, the protection of the public shall be paramount.

7. Section 725 of the Code states, in pertinent part:

> (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.
>
> (b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

8. Section 820 of the Code states, in pertinent part:

Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822.

9. Section 822 of the Code states, in pertinent part:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

10. Section 2234 of the Code, states in pertinent 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:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

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

(1) An initial negligent diagnosis followed by an act or omission medically 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.

...

11. Section 2266 of the Code states, in pertinent part:

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.

12. Section 2459.4 of the Code states, in pertinent part:

a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board 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 contendere 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.

(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) A violation of this section shall not be punishable as a crime.

(f) For purposes of this section:

(1) "Board" means the Osteopathic Medical Board of California.

(2) "Licensee" means a person licensed by the Osteopathic Medical Board of California.

COST RECOVERY

13. Section 125.3 of the Code states, in pertinent part:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

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

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

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

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

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

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

(k) Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licensee. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.

DEFINITIONS

14. The following chart contains a list of the medications prescribed by Respondent in this matter and pertinent information related to each of the medications. Many of the listed medications are only available by prescription and are dangerous drugs pursuant to California Business and Professions Code section 4022. All drugs that are scheduled by the DEA

Generic Name	Brand Name	DEA[1] Schedule	Medication Type
Phentermine	Lomaira, Adipex	IV	Stimulant, used for weight loss.
Armodafinil/Modafinil	Nuvigil/Provigil	IV	Stimulant, used for wakefulness.
Methylphenidate	Daytrana, Methylin, Ritalin	II	Stimulant, used to treat ADHD.[2]
Mixed Amphetamine Salts	Adderrall	II	Stimulant, used to treat ADHD.

[1] DEA stands for Drug Enforcement Agency, a federal agency under the Department of Justice, that federally schedules controlled substances based on their currently accepted medical use, their relative abuse potential, and the type of dependence they cause if abused. https://www.deadiversion.usdoj.gov/schedules/#define

[2] ADHD stands for Attention Deficit Hyperactivity Disorder

Lisdexamfetamine	Vyvanse	II	Stimulant, used to treat ADHD.
Methamphetamine Hydrochloride	Desoxyn	II	Stimulant, used to treat ADHD.
Aripiprazole	Abilify	No	Second Gen. Antipsychotic, used to treat schizophrenia, bipolar disorder, and depression.
Zolpidem Tartrate	Ambien	IV	Sedative, used to treat insomnia.
Alprazolam	Xanax	IV	Benzodiazepine, used to treat anxiety and panic disorders.
Sildenafil	Viagra	No	Vasodilator, used to treat erectile dysfunction.
Tadalafil	Cialis	No	Vasodilator, used to treat erectile dysfunction.
Guanfacine	Intuniv ER	No	Alpha Agonist, used to treat high blood pressure and ADHD.
Suvorexant	Belsomra	IV	Sedative, used to treat insomnia.
Prazosin	Minipress	No	Antihypertensive drug, used to treat high blood pressure.
Hydrocodone with Acetaminophen	Norco, Vicodin	II	Narcotic, used for treatment of pain.
Brexpiprazole	Rexulti	No	Atypical antipsychotic, serotonon-dopamine activity modulator.
Cariprazine	Vraylar	No	Atypical antipsychotic, used for treatment of schizophrenia, and bipolar disorder.

Bupropion	Wellbutrin	No	Antidepressant and smoking cessation aid.
Zonisamide	Zonegran	No	Anticonvulsant.
Clonazepam	Klonopin	IV	Benzodiazepine, treatment of panic disorders, anxiety and seizures.
Quetiapine	Seroquel	No	Antipsychotic, used to treat schizophrenia, bipolar disorder and depression.
Gabapetin	Gralise, Horizant, Neurontin	No	Anticonvulsant and nerve pain medication.
L-thyrozine	Tyrosine	No	Non-essential amino acid.
Rabeprazole	AcipHex	No	Proton-pump inhibitor.
Zonisamide	Zonegran	No	Anticonvulsant.
Duloxetine	Irenka, Cymbalta	No	Antidepressant and nerve pain medication.
Methadone	Methadose, Dolophine	II	Narcotic, used to treat moderate to severe pain, also used for drug addiction therapy/maintenance.
Fentanyl	Duragesic, Abstral, Subsys	II	Powerful narcotic, used to treat severe pain.
Meclizine	Bonine, Medi-Meclizine	No	Antihistamine, used to treat motion sickness and vertigo.
Promethazine	Phenergan, Phenadoz	No	Antihistamine and antiemetic, used to treat allergies and motion sickness.

Prochlorperazine	Compro	No	Antipsychotic and antiemetic, used to treat anxiety or schizophrenia.
Butalbital/ Acetaminophen/Caffeine	Fiorcet	III	Analgesic, used to treat acute headaches.
Atenolol	Tenormin	No	Beta-blocker.
Omeprazole	Zagerid	No	Proton-Pump Inhibitor.
Dexmethylphenidate	Focalin	II	Stimulant, used to treat ADHD.
Disulfiram	Antabuse	No	Used to treat alcoholism.
Oxcarbazepine	Trileptal	No	Anticonvulsant, used to treat seizures.
Liothyronine	Triostat	No	Hormone used to treat hypothyroidism.
Vortioxtine	Trintellix and Brintellex	No	Serotonin Modulator, used to treat major depressive disorder.
Apixaban	Eliquis	No	Anticoagulant, used to prevent blood clots.

FACTUAL ALLEGATIONS

Patient 1[3]

15. In 2008, Patient 1 received care and treatment for bipolar disorder, alcohol dependence, amphetamine dependence, chronic pain, and a history of opiate use disorder. At that time, physicians documented that Patient 1 was symptomatic with suicidality, delusions, paranoia, and mania. In March 2010[4], Respondent began to provide regular psychiatric treatment to Patient 1. In 2010, Respondent documented seeing Patient 1 approximately 14 times in his medical

[3] Patients are identified by an alpha numeric in order to protect confidentiality. All witnesses will be fully identified in discovery.

[4] All referenced to conduct before December 17, 2014, is for historical context only in order to explain care occurring after December 17, 2014, and will not serve as a basis for discipline.

office. At a March 2010 visit, Respondent noted that Patient 1 was on bupropion, armodafinil, quetiapine, zolpidem, and atomoxetine, and Respondent started Patient 1 on sildenafil. In 2010, Respondent documented that Patient 1 exhibited delusions, suspicions, paranoia and suicidal thoughts. Later in 2010, Respondent began Patient 1 on prescriptions for dexmethylphenidate, mixed amphetamine salts, clonazepam, disulfiram, oxcarbazepine, aripiprazole, melatonin, sildenafil, and liothyronine.

16. In 2011, Respondent saw Patient 1 approximately 16 times in his medical office. Of note, Respondent documented that Patient 1 was symptomatic for paranoia, threats of self-harm, and violent thoughts. On September 20, 2011, Respondent documented that Patient 1 wanted to return to rehab but Respondent failed to document Patient 1' drug of abuse. On December 14, 2011, Respondent documented that he was stopping Patient 1's prescription for mixed amphetamine salts because it increased his psychotic thoughts. By December 27, 2011, Respondent has Patient 1 back on a prescription of amphetamine salts.

17. In 2012, Respondent saw Patient 1 approximately 17 times in his medical office. On February 15, 2012, Patient 1 was noted as "not doing okay." On April 13, 2012, Patient 1 contacted Respondent's practice and noted he had relapsed on alcohol and had self-inflicted three abdominal wounds. On August 1, 2012, Respondent documented that Patient 1 believed that people were laughing at him. On October 31, 2012, Respondent documented that Patient 1 was in a deep depression.

18. Between January 2013 until June 2014, Respondent saw Patient 1 approximately 19 times in his medical clinic. On January 2, 2013, Respondent documented that Patient 1 reported delusions and on January 30, 2013, Patient 1 reported relapsing with alcohol. On April 2, 2013, Respondent documented that he received genetic testing for Patient 1, which indicated that Patient 1 had a normal response to amphetamines but had a reduced response to methylphenidate. On May 22, 2013, Respondent documented that Patient 1 occasionally received hydrocodone with acetaminophen. On July 23, 2013, Respondent responded to a request from Walgreens pharmacy regarding why he was prescribing Patient 1 lisdexamfetamine and Respondent stated it was in part due to a diminished response to stimulants based on his interpretation of the genetic

testing. On January 31, 2014, Respondent documented that Patient 1 felt hopeless. On March 5, 2014, Respondent documented that Patient 1 complained of vertigo. On June 21, 2014, Respondent documented that Patient 1 reported he was really struggling. Respondent started Patient 1 on phentermine and armodafinil, despite already prescribing three other dopamine agents including methylphenidate, mixed amphetamine salts, and lisdexamfetamine. Respondent started Patient 1 on these two additional controlled substances that work as dopamine agents despite Patient 1's documented history of substance abuse disorder.

19. On October 16, 2014, Respondent documented that Patient 1 complained of symptoms of non-reality. At that time, Patient 1 was on five scheduled psychotropics prescribed by Respondent including phentermine, armodafinil, methylphenidate, mixed amphetamine salts, and lisdexamfetamine. On December 18, 2014, Respondent documented that Patient 1 complained about being sleepy. Respondent documented that Patient 1 asked about prescription-methamphetamine (Desoxyn) and whether it could be added to his prescriptions. Despite Patient 1 already being prescribed five control-scheduled psychotropics including phentermine, armodafinil, methylphenidate, mixed amphetamine salts, and lisdexamfetamine, Respondent added Desoxyn to Patient 1's prescriptions. On May 7, 2015, Patient 1 reported unreality. Patient 1 was still on five control-scheduled psychotropics prescribed by Respondent including phentermine, armodafinil, methylphenidate, mixed amphetamine salts, and lisdexamfetamine but Desoxyn had been stopped. Respondent documented on July 30, 2015, that Patient 1 was endorsing visual hallucination and de-realization. On October 22, 2015, Respondent documented that Patient 1 exhibited symptoms of non-reality and is described as agitated and manic. On December 22, 2015, Respondent documented that Patient 1 was receiving his prescriptions from three different pharmacies.

20. In 2016, Respondent documented seeing Patient 1 in his medical clinic approximately 13 times. On January 21, 2016, Respondent documented that Patient 1 was doing well but failed to accurately enter the medication list on both the written and typed progress notes. On February 18, 2016, Respondent documented that Patient 1 reported poor sleep and Respondent started him on suvorexant. Patient 1 was receiving phentermine, methylphenidate, armodafinil, caffeine,

mixed amphetamine salts, lisdexamfetamine, aripiprazole, zolpidem and alprazolam. On September 8, 2016, Respondent documented that Patient 1 reported seeing "more crazy". On September 28, 2016, Costco pharmacy sent Respondent a copy of Patient 1's CURES report and requested a diagnosis and justification for Patient 1's prescriptions, in particular Patient 1's long-term phentermine prescription, as well as prescriptions for the many stimulants and sedatives Respondent was prescribing to Patient 1. On October 6, 2016, Respondent responded to the Costco pharmacy by stating that Costco's statement was "insulting and inappropriate." On October 6, 2016, Respondent started Patient 1 on sildenafil. On or about December 29, 2016, on a monthly basis, Patient 1 was receiving controlled substance prescriptions s including 90 tablets of .5 mg alprazolam, 60 tablets of 30 mg amphetamine salts, 30 tablets of 70 mg lisdexamfetamine, 30 tablets of 10 mg. zolpidem tartrate, 30 tablets of 37.5 mg phentermine hcl, 30 tablets of 20 mg methylphenidate hcl from Respondent. Patient was also receiving armodafinil, caffeine, aripiprazole and sildenafil.

21. In 2017, Respondent documented seeing Patient 1 in his medical clinic approximately 15 times. On approximately 12 occasions (January 1, 2017, February 2, 2017, March 7, 2017, April 7, 2017, May 9, 2017, June 11, 2017, July 7, 2017, August 15, 2017, September 19, 2017, October 16, 2017, November 17, 2017, and December 15, 2017) Patient 1 received 45 tablets of 10/325 mg hydrocodone with acetaminophen from other medical practitioners. Respondent failed to document that Patient 1 was receiving ongoing Schedule II opiates in Patient 1's medical records despite Respondent prescribing on-going stimulant and sedative prescriptions to Patient 1. On March 16, 2017, Respondent documented that he started Patient 1 on vortioxetine despite Respondent not documenting an apparent complaint from the patient. Respondent documented that Patient 1 was stable on March 16, 2017. On April 14, 2017, Respondent documented that Patient 1 was having more mania. On August 2, 2017, Respondent documented that Patient 1 reported more psychotic symptoms. On October 3, 2017, Respondent restarted Patient 1 on suvorexant without justifying the prescription in the medical chart. On or about October 11, 2017, on a disability form, Respondent documented that Patient 1 as having persecutory delusions, visual hallucinations, depressed and anxious mood, intense affect, and intense speech.

On November 22, 2017, Respondent documented that Patient 1's spouse reported that Patient 1 mumbles which could have been a sign of responding to internal stimuli and a symptom of on-going psychosis. Through Respondent's 2017 progress notes kept for Patient 1, there were varying degrees of incompleteness including inaccurate medication lists, illegible handwriting, and missing information.

22. In 2018, Respondent documented that he saw Patient 1 in his medical clinic 12 times. On approximately 12 occasions (January 16, 2018, February 15, 2018, March 15, 2018, April 15, 2018, May 16, 2018, June 16, 2018, July 16, 2018, August 15, 2018, September 15, 2018, October 16, 2018, November 16, 2018, and December 16, 2018) Patient 1 received 45 tablets of 10/325 mg hydrocodone with acetaminophen from other medical practitioners. Respondent failed to document that Patient 1 was receiving Schedule II opiates in Patient 1's medical records despite Respondent prescribing on-going stimulant and sedative prescriptions to Patient 1. On January 18, 2018, February 22, 2018, and April 18, 2018, Respondent's progress note for Patient 1's treatment consists of only the patient's name and date; the rest of the note is blank. On May 23, 2018, Respondent documented that Patient 1 was having flashbacks and panic attacks. On August 16, 2018, Respondent documented a mostly illegible handwritten progress note related to Patient 1's current psychiatric symptoms and a typed progress note that contains no information about Patient 1's current psychiatric symptoms. On August 16, 2018, Respondent started Patient 1 on guanfacine without documenting a medical reason and failed to note that Patient 1 was also prescribed suvorexant. Patient 1 remained on phentermine, methylphenidate, armodafinil, mixed amphetamine salts, Lisdexamfetamine, aripiprazole, zolpidem, alprazolam, tadalafil, and sildenafil. On October 11, 2018, Respondent documented that Patient 1 complained of vertigo but Respondent did not document performing an assessment of this complaint. On November 8, 2018, Respondent documented that Patient 1 complained of psychosis. On December 12, 2018, Respondent documented that Patient 1 reported being anxious and having nightmares and Respondent started him on prazosin. A portion of Respondent's 2018 progress notes for Patient 1 contain incomplete, incorrect or missing medication lists despite Respondent repeatedly prescribing controlled substances throughout 2018.

23. In 2019, Respondent documented that he saw Patient 1 in his medical clinic approximately 13 times. On approximately 9 occasions (January 14, 2019, February 15, 2019, March 16, 2019, April 15, 2019, May 16, 2019, June 16, 2019, July 16, 2019, August 16, 2019, September 16, 2019) Patient 1 received 50 to 90 tablets of 10/325 mg hydrocodone with acetaminophen from other medical practitioners. Respondent failed to document that Patient 1 was receiving Schedule II opiates in Patient 1's medical records despite Respondent prescribing on-going stimulant and sedative prescriptions to Patient 1. On October 17, 2019, Respondent documented for the first time between 2017 and 2019 that Patient 1 was receiving on-going opiates from other medical providers. On July 26, 2019, Respondent documented that Patient 1's anxiety was worsening. On September 18, 2019, Respondent documented that Patient 1 was having trouble getting into the shower. On November 14, 2019, Respondent documented that Patient 1 complained of weight gain and Respondent switched Patient 1's prescription from aripiprazole to brexpiprazole.

24. In 2020, Respondent documented that he saw Patient 1 in his medical clinic approximately nine times. On January 2020, Respondent was still prescribing armodafinil, zolpidem, methylphenidate, alprazolam, mixed amphetamine salts, Lisdexamfetamine, phentermine, prazosin, suvorexant, and brexpiprazole to Patient 1. On January 24, 2020, Respondent received a letter from Express Scripts' pharmacy benefit manager warning that Patient 1 was on multiple CNS[5] depressants and multiple stimulants that could worsen psychosis. On June 30, 2020, Respondent received a similar letter from Express Scripts' pharmacy benefit manager that provided similar warnings regarding Patient 1's prescriptions and Respondent wrote on the letter that the warnings were not relevant to his patient. Respondent did not change Patient 1's medication based on these warnings. On March 4, 2020, the Respondent documented that Patient 1 indicated he was, "taking himself off the ledge". On April 29, 2020, Respondent documented that Patient 1 reported he was going through rough patches with bipolar symptoms and unreality. On July 28, 2020, Respondent documented that Patient 1 reported delusions but

[5] CNS stands for central nervous system.

the rest of the handwritten note is illegible. On August 25, 2020, Respondent documented that Patient 1 reported being "wasted".

Patient 2

25. Respondent provided psychiatric care to Patient 2 for major depressive disorder, post-traumatic stress disorder and insomnia due to other mental disorders. Respondent also provided pain management care for patient 2's complaints of chronic cephalagia, osteoarthritis, and bruxism with temporo-mandibular joint pain and inflammation. Respondent also documented that he managed Patient 2's bronchiectasis, which was first diagnosed in October 2005. On January 11, 2017, Respondent was prescribing Patient 2 bupropion, mixed amphetamine salts (120-10 mg tablets per month) , zonisamide, clonazepam (120-2 mg tablets per month), quetiapine, zolpidem tartrate (30-10 mg tablets per month), naproxen, hydrocodone with acetaminophen (135-10/325 mg tablets per month), and folate OTC. A primary care physician was prescribing gabapentin, L-thyrocine, rabeprazole, and flaxeed oil OTC to Patient 2. Patient 2 turned 63 years old in 2017.

26. In 2017, Respondent documented seeing Patient 2 in his medical clinic approximately 10 times. On April 18, 2017, June 13, 2017, and October 4, 2017, patient 2's medical records indicate that she was medically hospitalized. On April 18, 2017, the note references that medical professionals recommended Patient 2 stop her zonisamide and decrease her quetiapine. On August 8, 2017, Respondent documented that Patient 2 had gone to the emergency room due to a concussion. On October 4, 2017, Respondent documented that Patient 2 have been in the hospital and the hospital had held her zolpidem prescription because it caused Patient 2 confusion. On November 30, 2017, Respondent documented that Patient 2 reported poor sleep and he noted that she had never been prescribed suvorexant. In November 2017 and December 2017, Respondent prescribed a monthly prescription of 60 tablets of 10 mg zolpidem tartrate to Patient 2 for sleep, twice the recommended daily dose. Respondent provided samples of suvorexant, an additional sleep aid, to Patient 2 without discontinuing her zolpidem tartrate prescription.

27. In 2018, Respondent documented seeing Patient 2 in his medical clinic approximately 12 times. On February 21, 2018, a pharmacy contacted Respondent's medical office to confirm

whether Patient 2 was supposed to be receiving a 30 mg daily dose of zolpidem tartrate after Patient 2 claimed that Respondent was now prescribing a 30 mg daily dose of zolpidem tartrate. In March 2018, according to CURES and certified pharmacy records Respondent began prescribing a daily dose of 30 mg zolpidem tartrate to Patient 2, three times the recommended daily dose. On April 25, 2018, Respondent documented that Patient 2 was taking zolpidem tartrate 10 mg and made a notation of "2+1" in her medical chart but failed to provide a rationale for Patient 2's 30 mg daily dose of zolpidem tartrate. On two prescriptions dated April 25, 2018, Respondent documented to the pharmacy that Patient 2 was taking 30 mg of zolpidem tartrate at bedtime (90 10 mg tablets per month) and that her insurance was paying for sixty tablets and that Patient 2 was paying cash for the other 30 tablets. Respondent's two separate zolpidem prescriptions, one for sixty tablets and one for thirty tablets, avoided Patient 2's insurance company oversight of his daily dosing of a 30 mg prescription of zolpidem tartrate at bedtime. On June 20, 2018, Respondent documented that Patient 2 reported having dizzy spells requiring her to sit down and had been in bed for two days due to exhaustion. At that time, Respondent was prescribing a daily dose of 40 mg amphetamine salts, 8 mg of clonazepam, 30 mg of zolpidem tartrate, 40/1300 mg hydrocodone with acetaminophen, bupropion, quetiapine, naproxen, folate OTC. On July 18, 2018, Respondent documented that Patient 2 reported she had been previously diagnosed with dementia.

28. On August 1, 2018, Respondent received a letter from Patient 2's pharmacy asking him to reassess the high doses of Adderall, clonazepam, and zolpidem tartrate he was prescribing to Patient 2 due to contradictory mechanisms of action. Respondent handwrote a partially illegible response to the pharmacy that included, "First, where would I find evidence of the abstract concept that supports use of medications that have some actions that are opposite? Where can I find information?" Between August 1, 2018, and September 30, 2018, Respondent made no changes to Patient 2's prescriptions and did not perform a reevaluation of her prescriptions, keeping her on monthly prescriptions of 90 tablets 10 mg zolpidem tartrate, 120 tablets of 10 mg amphetamine tartrate, 120 tablets of 2 mg clonazepam, and 135 tablets of 10/325 mg hydrocodone with acetaminophen. On August 15, 2018, Respondent documented that Patient 2

reported that she could not stand long enough to brush her teeth and had to sit down. On September 26, 2018, Respondent wrote a letter to a pharmacy in response to a pharmacy denial of Patient 2's Adderall prescription. Respondent stated in the letter that he prescribed Adderall to deal with fatigue from bronchiectasis. Respondent's letter falsely asserted that Patient 2 was only receiving a daily dose of 20 mg of zolpidem tartrate rather than a daily dose of 30 mg of zolpidem tartrate split between two prescriptions he was specifically writing for that purpose. On October 18, 2018, November 8, 2018, and December 6, 2018, Respondent authored handwritten notes that were illegible regarding Patient 2's current care and treatment. On November 29, 2018, Respondent received a letter from Patient 2's insurance indicating a concern for misuse/abuse potential related to Respondent's long-term prescription of opiates concurrent with stimulants and sedatives.

29. In 2019, Respondent documented seeing Patient 2 approximately 17 times in his medical clinic. On January 31, 2019, Respondent received a letter from Patient 2's insurance highlighting the misuse/abuse potential of opiates while being concurrently prescribed stimulants and sedative hypnotics. Respondent responded to the letter by writing, "(a)bsurd conceptualization given her (history). Have explained at length previously." Respondent made no changes to her prescriptions. On March 7, 2019, March 20, 2019, and March 22, 2019, Respondent documented typed progress notes for Patient 2 but did not document corresponding written notes that would have explained her current diagnosis and current patient status. On July 18, 2019, Respondent documented that Patient 2 reported that she fell and suffered a concussion. Respondent was prescribing bupropion, mixed amphetamine salts, clonazepam, quetiapine, zolpidem, naproxen, hydrocodone with acetaminophen, and folate OTC. Patient 2 was also receiving gabapentin, thyroxine, rabeprazole, apixaban and Flaxseed oil from her primary care physician.

30. On July 30, 2019, Respondent received a letter from Patient 2's medical insurance company as part of their retrospective drug utilization review program, which noted that Patient 2 remained on opiates in combination with benzodiazepines, sleep sedatives, and stimulants and mentioned a risk of misuse/abuse potential. Respondent wrote, "answered before" on the letter

and made no changes to Patient 2's medical records. On October 22, 2019, Respondent documented that Patient 2 reported poor balance and had ecchymosis. Between November 8, 2019, and November 15, 2019, Patient 2 or Patient 2's relative called on four occasions for early refill of mixed amphetamine salts because she had lost her medication. Despite this obvious red flag, Respondent failed to document a written progress note regarding early refills of medication. On November 25, 2019, Respondent received a letter from patient's medical insurance company as part of their safety management program, which noted that Patient 2 was on three or more CNS-Active drugs, and that she was an older adult at risk of fall due to the medications. The insurance company's letter cited articles from both the Pharmacy Quality Alliance and the American Geriatrics Society 2019 Updated Beers Criteria in support of their analysis. Respondent wrote "see previous" on the letter and made no changes to Patient 2's medications.

31. Between January 2017 and December 2019, Respondent failed to keep accurate and adequate medical records for Patient 2. Patient 2's medical records often had incomplete, missing and inaccurate medication logs despite Respondent prescribing multiple controlled substances to Patient 2 who was undergoing a complex treatment regimen. Respondent failed to document that he performed adequate assessments, reviewed pertinent symptoms, performed mental status exams, explain Patient 2's diagnoses, and provide any justification for any of Patient 2's treatments plans. While Respondent documented a few assessments, such as one on September 26, 2018, that assessment was not adequate in explaining the medication regimen or the frequent side effects experienced by Patient 2. Respondent's documentation failed to include drug screens, medical rationale, and substance abuse assessments. Finally, Respondent's documentation failed to set forth any assessment of Patient 2's risk while being prescribed multiple controlled substances.

Patient 3

32. Between December 2016 and December 2017, Respondent documented seeing Patient 3 in his medical clinic approximately 15 times. Respondent treated Patient 3 for major depressive disorder, generalized anxiety disorder, dementia, and chronic pain syndrome. On December 13, 2016, Respondent documented that Patient 3 reported trouble swallowing,

including choking on water. Respondent was prescribing duloxetine, gabapentin, 175 mcg/hr. fentanyl patches every two days, 80 mg methadone per day, 1 mg clonazepam per day, 8 mg alprazolam per day, 4 doses of Fiorcet per day, lidocaine patch, meclizine, promethazine, and prochlorperazine. Patient 3's primary physician was prescribing l-thyrozine, atenolol, and omeprazole. Respondent documented that Patient 3 had a diagnosis of dementia. Between December 2016 and November 2019, Respondent's opioid prescriptions as noted above (262.5 mcg per hour of fentanyl and 80 mg of methadone) equated to a morphine equivalent dose (MED) of at least 870.[6]

33. On January 11, 2017, Respondent documented that Patient 3 complained of pain in her feet. On February 8, 2017, Respondent documented that Patient 3 complained of extreme pain requiring her to stay in bed and suicidal thoughts. On March 8, 2017, Respondent documented that Patient 3 reported two fractures. On May 9, 2017, Respondent documented that Patient 3 was in a lot of pain. On June 8, 2017, Respondent's handwritten note documented Patient 3's care was illegible. On July 7, 2017, and July 11, 2017, Respondent's handwritten progress notes included only the dates. On August 2, 2017, Respondent received a message from a pharmacy regarding Patient 3's meclizine prescription. Respondent was prescribing 150 mg of meclizine a day to Patient 3 and the pharmacy noted that 100 mg was maximum recommended dose. On August 3, 2017, Respondent documented that Patient 3's depression and pain control are noted to be poor.

34. On August 30, 2017, Respondent documented that Patient 3 reported that she was feeling "drugged" from her medication. On September 28, 2017, Respondent documented that Patient 3 reported only sleeping 2 hours at a time. The September 28, 2017, progress note's medication list was missing clonazepam, alprazolam, meclizine, promethazine, prochlorperazine, butalbital/acetaminophen/caffeine. In November 29, 2017, Respondent documented that Patient 3 was considered to likely suffer from subacute combined degeneration of the spinal cord.

[6] https://www.oregonpainguidance.org/opioidmedcalculator/. A morphine equivalent dose (MED) or morphine milligram equivalents (MME) provides an apple-to-apple comparison for different opiate agents. As noted in the 2016 CDC opiate guidelines, clinicians should avoid a dosage greater than 90 MME per day.

Respondent failed to order appropriate labs, imaging, and document performing a physical examination to confirm the diagnosis of subacute combined degeneration of the spinal cord. On December 22, 2017, Respondent's progress note included an inaccurate medication list; the list did not include duloxetine, methadone, gabapentin, fentanyl, meclizine, promethazine, and prochlorperazine.

35. In 2018, Respondent documented seeing Patient 3 in his medical clinic approximately 10 times. On March 20, 2018, Respondent documented that Patient 3 reported having generalized myoclonus and slurred speech. Patient 3 was receiving prescriptions for duloxetine, gabapentin, methadone, fentanyl, clonazepam, alprazolam, lidocaine, meclizine, promethazine, prochlorperazine, Fiorcet, from Respondent. Patient 3 was also receiving 1-thyroxine, atenolol, B12, omeprazole, urea cream, and D3 from her primary care physician. On March 20, 2018, and April 3, 2018, Respondent received a request for documentation from the Social Security Administration related to Patient 3's disability including complaints of memory loss, balance issues, trouble writing, and brain injury. On April 26, 2018, Respondent documented that Patient 3 reported she had been hospitalized and that she had experienced a convulsion. On that same day, Patient 3 executed a pain contract for chronic opiate therapy. On May 22, 2018, Respondent documented that Patient 3 reported that she had significant depression and suicidal thoughts.

36. On June 28, 2018, Respondent documented only a medication list in the handwritten progress note for Patient 3. On or about July 10, 2018, Patient 3 underwent an independent psychiatric evaluation for her social security disability. The independent evaluator determined that Patient 3 exhibited impairment on cognitive testing and had mild neurocognitive disorder. On September 6, 2018, Respondent documented that Patient 3 reported that she had 4 migraines per week. On October 10, 2018, and November 8, 2018, Respondent's handwritten progress notes only contained the date. In 2018, Respondent received letters from Patient 3's healthcare insurance provider stating that Patient 3 was on a high dose of opioids and referred Respondent to the CDC guidelines for prescribing opioids for chronic pain. Respondent did not lower Patient 3's opioid dosages.

///

37. In 2019, Respondent documented that he saw Patient 3 in his medical clinic approximately 14 times. On February 5, 2019, Respondent documented that Patient 3 complained of a burning sensation, numbness, diplopia, and seeing black dots. The February 5, 2019, progress note's medication list did not include fentanyl despite Respondent's on-going prescription. On March 12, 2019, Respondent documented that Patient 3 complained of depression. Respondent continued to prescribe duloxetine, gabapentin, methadone, fentanyl, clonazepam, alprazolam, lidocaine patch, meclizine, promethazine, prochlorperazine, Fiorcet to Patient 3. Patient 3 was continuing to receive l-thyroxine, atenolol, B12, omeprazole, urea cream, and D3 from her primary care physician. On April 17, 2019, Respondent documented a handwritten note for Patient 3 that only included a date and a longer form typed note that failed to provide Patient 3's status. On May 7, 2019, Respondent documented that Patient 3 reported that she had not taken her prescribed lidocaine patch for one to two years.

38. On May 30, 2019, Respondent documented Patient 3 was having continued pain and Respondent documented that he was considering adding CBD or hydrocodone to her treatment regimen. On June 26, 2019, Respondent documented an illegible handwritten progress note. On July 26, 2019, and August 30, 2019, Respondent documented that Patient 2 was being tapered off clonazepam. On August 30, 2019, Respondent documented that Patient 3 was complaining of nausea and migraines. On September 19, 2019, Respondent documented that Patient 3 reported being in extreme pain and just lying in bed. On October 25, 2019, Respondent documented that Patient 3 reported palpitations and difficulty breathing. On November 22, 2019, Respondent documented that Patient 3 reported that she was suffering from extreme pain that limited her activities.

39. On June 6, 2019, Respondent received notification from Prime Therapeutics, LLC, a pharmacy claim reviewer for Blue Cross health insurance that raised concerns with Respondent's fentanyl prescriptions to Patient 3. On June 13, 2019, Respondent received notification from Prime Therapeutics that raised concerns with Respondent's opioid prescriptions that were in combination with benzodiazepine prescriptions to Patient 3. On October 16, 2019, Respondent received a letter from Blue Cross health insurance raising concerns with Respondent prescription

of an opioid dosage above 90 MME per day and raising concerns with Respondent prescribing opioids in combination with benzodiazepines to Patient 3. In November 2019, Respondent continued to prescribe 3 mg alprazolam in combination with 262.5 mcg/hour fentanyl and 80 mg of methadone to Patient 3.

40. Between December 2016 and December 2019, Respondent failed to document proper medical records for Patient 3 despite her complex diagnoses, severe presentations, and complex treatment regimen. Respondent often documented illegible handwritten notes. Respondent's clinical record for Patient 3 lacked adequate assessments, a review of patient symptoms, mental status examinations, explanation of diagnoses, accurate medication lists, and justification of treatment plans. Respondent's medical documentation failed to provide a thorough and frequent record of Patient 3's complex symptoms of depression, anxiety, loss of cognition, chronic pain, and suicidality.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

41. Respondent's license is subject to disciplinary action under sections 3600, 2450, and 2234, subdivision (b), of the Code in that he committed gross negligence during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

42. Complainant realleges paragraphs 15 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

43. Respondent committed the following acts of gross negligence during the care and treatment of Patients 1, 2, and 3, separately and collectively, in the following ways:

a.) As set forth above, Respondent's continued prescription of high dose stimulants, at times six medications together, to Patient 1, who had a history of substance abuse and psychosis, while at the same time Respondent failed to adequately document the medical records, and while Patient 1 appeared to be having potential side effects from those medications;

b.) As set forth above, Respondent's continued prescription of three CNS sedatives to Patient 1 while Patient 1 was receiving opiate prescriptions, and had a history of substance

abuse disorder, while at the same time Respondent failed to adequately document the medical records, and while Patient 1 appeared to be having potential side effects from the medications;

c.) As set forth above, Respondent's continued prescribing of multiple dopamine agents to Patient 1 while Patient 1 was reporting frequent, chronic, and unremitting psychosis without ever addressing Patient 1's psychosis, while at the same time Respondent failed adequately document the medical records;

d.) As set forth above, Respondent's failure to address Patient 1's reports of suicidality and Respondent's failure to perform and/or document a comprehensive suicide risk assessment of Patient 1;

e.) As set forth above, Respondent's failure to perform basic medical documentation while treating Patient 1's complex diagnoses, address Patient 1' severe presentations and while prescribing Patient 1's complex treatment regimen;

f.) As set forth above, Respondent's continued prescribing of multiple dangerous and addicting medications to Patient 2 without apparent medical rationale despite repeated warning signs of excessive prescribing including reports of falls, dizziness, confusion, and dementia;

g.) As set forth above, Respondent's failure to perform basic medical documentation while treating Patient 2 including failing to document adequate assessments, failing to review pertinent symptoms, failing to perform mental status exams, failing to explain diagnoses, failing to keep accurate medication lists, and failing to justify treatment plans;

h.) As set forth above, Respondent's continued prescribing of high dose opiates, long-term barbiturates, benzodiazepines, and high dose anticholinergics, to Patient 3 despite warning signs of excessive prescribing including dementia, continued pain, and falls;

i.) As set forth above, Respondent's failure to perform a suicide risk assessment of Patient 3 or further evaluation of Patient 3's suicidality despite documenting Patient 3 reported suicidal thoughts on February 8, 2017, and May 22, 2018; and

j.) As set forth above, Respondent's failure to perform basic medical documentation while treating Patient 3 including failing to document adequate assessments, failing to review

pertinent symptoms, failing to perform mental status exams, failing to explain diagnoses, failing to keep accurate medication lists, and failing to justify treatment plans.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patients 1, 2, and 3)

44. Respondent's license is subject to disciplinary action under sections 3600, 2450, and 2234, subdivision (c), of the Code in that he committed repeated negligent acts during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

45. Complainant realleges paragraphs 15 and 43, and those paragraphs are incorporated by reference as if fully set forth herein.

46. Respondent committed the following negligent acts during the care and treatment of Patients 1, 2, and 3:

a.) On December 18, 2014, Respondent started Patient 1 on methamphetamine despite a history of methamphetamine use disorder and a complaint of psychosis two months earlier;

b.) On October 22, 2015, Respondent restarted Patient 1 on a dopamine agent despite Patient 1 complaining of psychosis;

c.) On February 18, 2016, Respondent started Patient 1 on a controlled sleep agent, Suvorexant, despite the patient being on five activating dopamine agents and prescribed caffeine;

d.) On October 6, 2016, Respondent started Patient 1 on a blood pressure altering medication (sildenafil) without performing and/or documenting a physical exam or monitoring of vitals;

e.) On April 14, 2017, Respondent continued to prescribe five dopamine agents to Patient 1 that can worsen mania despite Patient 1 complaining of being manic;

f.) On October 3, 2017, Respondent restarted a controlled medication (suvorexant) without legible documentation or medical justification;

g.) On October 11, 2018, Respondent failed to address or assess Patient 1's complaint of vertigo;

h.) On May 2, 2019, Respondent restarted a controlled medication (suvorexant) without legible documentation or medical justification;

i.) On September 18, 2019, Respondent failed to perform an evaluation or assessment despite Patient 1 reporting symptoms that represent severe psychosis of severe depression;

j.) On March 4, 2020, Respondent failed to perform and/or document a suicide risk assessment despite Patient 1 implying possible suicidality;

k.) On April 29, 2020, Respondent continued to prescribe five dopamine agents to Patient 1 that can worsen psychosis despite the fact Patient 1 was reporting symptoms of psychosis;

l.) On August 25, 2020, Respondent failed to further evaluate Patient 1's claim that he was "wasted" and make changes to Patient 1's treatment plan.;

m.) Between January 2017 and October 2019, Respondent failed to incorporate into Patient 1's treatment plan and/or document that Patient 1 was receiving opiate prescriptions from other medical providers;

n.) Between July 2014 and July 2020, Respondent continued to prescribe phentermine to Patient 1;

o.) Between December 2016 and November 2019, Respondent continued prescribe 60 mg of mixed amphetamine salts to Patient 1 without performing and/or documenting an appropriate evaluation for narcolepsy;

p.) Between December 2016 and November 2019, Respondent continued to prescribe 60 mg of mixed amphetamine salts in combination with Lisdexamfetamine to Patient 1;

q.) Between December 2014 and August 2020, Respondent failed to document that Patient 1 continued to receive medications from three different pharmacies, a concerning risk factor for substance abuse;

r.) Between October 2014 and July 2020, Patient 1 reported symptoms of psychosis nine times, yet Respondent kept prescribing multiple dopamine agents (at times up to 6) that can worsen psychosis and increased Patient 1's risk of harm;

s.) Between January 2016 and July 2020, Respondent's progress notes for Patient 1 were illegible, contained inaccurate medication lists, either missing information or contained different information between the written and typed notes. In addition, Respondent's progress notes for Patient 1 often failed to include medical justification for the prescriptions being issued.

t.) Between January 2017 and December 2019, Respondent continued to prescribe multiple dangerous addictive drugs to Patient 2 without performing proper assessment of symptoms despite warning signs of excessive prescribing including reports that Patient 2 needed treatment for concussions, experienced falls, experienced dizziness, couldn't stand, experienced confusion, and reported poor balance;

q.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing three or more CNS-active drugs to Patient 2;

r.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing opioids and benzodiazepines in combination to Patient 2;

s.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing opioids to Patient 2 in combination with gabapentin, which was being prescribed by her primary care physician;

t.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing an excessive dose of benzodiazepines (8 mg clonazepam) to Patient 2;

u.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing an excessive dose of zolpidem tartrate (20 mg from January 2017 to January 2018, 30 mg from March 2018 to November 2019);

v.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by

prescribing antipsychotics, benzodiazepines, sleeping sedatives, and opioids in combination to a patient with a history of falls;

w.) Between January 2017 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 2, an older adult, which placed her at a greater risk of harm by prescribing antipsychotics, benzodiazepines, sleeping sedatives, and opioids to a patient with a history of dementia;

x.) Between January 2017 and December 2019, Respondent repeatedly prescribed opioids to Patient 2 without medical rationale, without appropriate follow-up, and without performing drug screens and substance abuse assessments;

y.) Between January 2017 and December 2019, Respondent repeatedly prescribed CNS depressants to Patient 2 in direct contradiction to her medical diagnosis of bronchiectasis as CNS depressants can slow breathing and worsen pulmonary conditions;

z.) Between January 2017 and December 2019, Respondent failed to evaluate Patient 2's bronchiectasis by performing and/or documenting physical exams and/or taking vital signs;

aa.) Between January 2017 and December 2019, Respondent failed to perform basic medical documentation while treating Patient 2 including failing to document adequate assessments, failing to review pertinent symptoms, failing to perform mental status exams, failing to explain diagnoses, failing to keep accurate medication lists, and failing to justify treatment plans;

bb.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing three or more CNS-active drugs to Patient 3;

cc.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing opioids and benzodiazepines in combination to Patient 3;

///

///

dd.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing opioids in combination with gabapentin to Patient 3;

ee.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing benzodiazepines to Patient 3;

ff.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing anticholinergics, specifically meclizine, promethazine, and prochlorperazine, without proper justification to Patient 3;

gg.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing barbiturates, specifically Fiorcet, to Patient 3 despite the package insert for the medication specifically stating that extended and repeated use was not recommended;

hh.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing antipsychotics, benzodiazepines, and opioids in combination to Patient 3 despite Patient 3 having a history of instability and fractures;

ii.) Between December 2016 and December 2019, Respondent repeatedly prescribed inappropriate medication to Patient 3, an adult with dementia and cognitive issues, which placed her at a greater risk of harm by prescribing antipsychotics, benzodiazepines, and opioids in combination to Patient 3 despite Patient 3 having a history of dementia; and,

jj.) Between December 2016 and December 2019, Respondent failed to perform basic medical documentation while treating Patient 3 including failing to document adequate assessments, failing to review pertinent symptoms, failing to perform mental status exams, failing to explain diagnoses, failing to keep accurate medication lists, and failing to justify treatment plans.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

47. Respondent's license is subject to disciplinary action under sections 3600, 2450, and 2266 of the Code in that the Respondent failed to keep adequate and accurate medical records while treating Patients 1, 2, and 3. The circumstances are as follows:

48. Complainant realleges paragraphs 15 through 46, and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

49. Respondent's license subject to disciplinary action under section 3600, 2450, and 725 of the Code in that Respondent provided excessive prescriptions to Patients 1, 2, and 3, without appropriate medical indication. The circumstances are as follows:

50. Complainant realleges paragraphs 15 through 48, and those paragraphs are incorporated by reference as if fully set forth herein.

SPECIAL ALLEGATION

(PATIENT HARM)

51. Upon the imposition of a term of probation five years or greater and a determination that Respondent engaged in inappropriate prescribing to two or more patients, Respondent's license is subject to the imposition of probation disclosure requirements contained in section 2459.4 of the Code upon a finding that Respondent caused harm to Patients 1, 2, 3.

52. Complainant realleges paragraphs 15 through 50, and those paragraphs are incorporated by reference as if fully set forth herein.

53. Respondent's inappropriate prescribing caused harm to Patients 1, 2, and 3, in the following ways:

a.) As alleged above, Respondent repeatedly documented Patient 1 suffered from varying levels of psychosis, mania, vertigo, depression and implied possible suicidality between December 2014 and August 2020, yet Respondent continued to prescribe stimulant medications

that can worsen psychosis and mania and continued to prescribe CNS depressants that can worsen depression which caused harm to Patient 1;

b.) As alleged above, Respondent repeatedly documented that Patient 2 suffered from falls, dizziness, confusion, and concussions between January 2017 and December 2019, yet Respondent continued to prescribe CNS depressants to Patient 2 that worsened cognition and ambulation which caused hard to Patient 2; and,

c.) As alleged above, Respondent repeatedly documented that Patient 3 suffered from impairment, cognitive decline, dementia, suicidal thoughts, slurred speech, memory issues, signs of depression, and fractures between December 2016 and December 2019, yet Respondent continued to prescribe CNS depressants to Patient 3 that can worsen cognition, ambulation, and depression which caused harm to Patient 3.

FACTUAL ALLEGATIONS

Mental/Physical Impairment

54. On May 24, 2019, the Board received an anonymous complaint that Respondent was overprescribing medications, was providing false statements regarding disability, and was falling asleep during treatment sessions with patients. The complaint also alleged that Respondent, a practicing psychiatrist, was prescribing providing early refills of controlled substance prescriptions to patients. On December 30, 2019, the investigation was assigned to the Health Quality Investigation Unit (HQIU) at the Department of Consumer Affairs. On July 15, 2020, HQIU Investigator S.C. went to Respondent's medical office and spoke with him. Investigator S.C. told Respondent that the Board had received a complaint that Respondent was falling asleep or otherwise having a difficult time staying alert during patient appointments. Respondent did not deny the allegations and confirmed that it was not uncommon for him to lose focus during patient appointments and that on several occasions in the past he has fallen asleep during appointments. Respondent stated that he attributed his difficulty maintaining alertness to fatigue caused by sleep apnea. Respondent stated that he has difficulty staying alert the next day when he failed to use

his CPAP[7] machine the night before an appointment. Respondent stated that he was falling asleep on average "once or twice" a week. The Board reviewed Respondent's pertinent medical history between December 17, 2007, and July 15, 2020. His prior medical history did not mention whether Respondent had a problem with falling asleep at work or whether he suffered from a lack of alertness.

55. On September 4, 2020, and September 5, 2020, Respondent was interviewed by a forensic psychiatrist on behalf of the Board. The September 4, 2020, meeting over videoconference, was scheduled to begin at 11:00 a.m. but did not start until 11:50 a.m. When Respondent finally logged into the appointment, he stated that he was late to the appointment because he had not used his CPAP machine and had not slept well. Respondent admitted that he was supposed to also meet with his lawyer that morning but had missed that appointment entirely. The September 5, 2020, meeting over videoconference, was scheduled to occur at 2:00 p.m. but did not start until 4:50 p.m. While waiting for the Respondent to log in to his September 5, 2020, appointment, the Board psychiatrist tried to send messages to Respondent to have him log in to the appointment but Respondent did not respond to repeated text messaging. When Respondent finally logged into the appointment, Respondent admitted he had just awoken in a chair located in his medical records room.

56. The forensic psychiatrist found Respondent's mental health was relatively under control but that his sleep apnea was incompletely treated and could negatively impact his ability to ensure continued stability of his mental health. The Board psychiatrist found no evidence of a substance abuse disorder or a cognitive disorder. The Board psychiatrist determined that Respondent's sleep apnea was impacting his ability to provide safe and quality patient care. The Board psychiatrist stated that Respondent's sleep issues including falling asleep during treatment sessions which could cause harm to patients because he could miss information that was important to their care. The Board psychiatrist determined that Respondent required additional

[7] Continuous Positive Airway Pressure machine is used to treat sleep apnea by forcing a stream of oxygenated air into a patient's airways.

monitoring, treatment, and oversight of his sleep issues and that he was in need of further evaluation and treatment before he was completely safe to practice medicine.

57. On December 4, 2020, Respondent was physically examined by a family medicine physician hired by the Board. The family medicine physician recommended that the Respondent undergo a sleep study and receive on-going care from a sleep disturbance specialist. The family medicine physician stated that an evaluation from a sleep disturbance specialist of the Respondent's response to treatment should examine his ability to focus on his patients and practice in a safe manner. The family medicine physician did not find any other issues of note related to Respondent's ability to treat patients.

FIFTH CAUSE FOR DISCIPLINE

(Mental/Physical Impairment Impacting Ability to Safely Practice Medicine)

58. Respondent's license is subject to restriction under section 822 of the Code in that his ability to practice medicine safely is impaired to due to a mental/physical illness, to wit: untreated sleep apnea. The circumstances are more particularly alleged in paragraphs 54 through 57 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein. In order for Respondent to safely practice medicine his condition requires additional monitoring, treatment, and oversight of his sleep issues and he is in need of further evaluation and treatment before he is completely safe to practice medicine.

PRAYER

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

1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number 20A 6351, issued to Mark Hamilton Henigan, D.O.;

2. Revoking, suspending or denying approval of Mark Hamilton Henigan, D.O.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mark Hamilton Henigan, D.O. to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Ordering Mark Hamilton Henigan, D.O. to provide patient notification of his probation status upon the imposition of a probationary period of five or more years and a finding that he engaged in inappropriate prescribing resulting in harm to two or more patients, pursuant to Business and Professions Code section 2459.4; and,

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

DATED: December 9, 2021

Mark M. Ito

MARK M. ITO
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2021304436
35719114.docx

DECLARATION OF SERVICE BY MAIL

In the Matter of the Accusation Against:

Mark Hamilton Henigan, D.O.
Case No: 900-2019-000221

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

DECISION AND ORDER
STIPULATED SETTLEMENT AND DISCIPLINARY ORDER

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

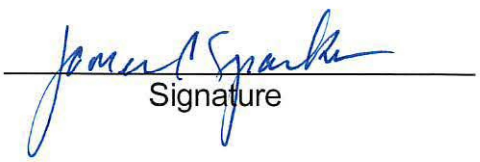
NAME AND ADDRESS	CERT NO.
Mark Hamilton Henigan, D.O. 930 Alhambra Blvd. Suite 280 Sacramento, CA 95816-4479	9489 0090 0027 6244 3706 91

Each said envelope was then, on August 16, 2022, sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid and return receipt requested.

Executed on August 16, 2022, at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

James C. Sparks
Typed Name


Signature

cc: John S. Gatschet, Deputy Attorney General
Bruce E. Salenko, Esq.