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

In the Matter of the Accusation Against **Alan Ogden Marcus, M.D.** **Physician's and Surgeon's License No. A39696** **Respondent.**	**Case No. 800-2016-024668**

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 3, 2020.

IT IS SO ORDERED: June 4, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against: **ALAN OGDEN MARCUS, M.D.** 24422 Avenida De La Carlota, Suite 375 Laguna Hills, CA 92653 **Physician's and Surgeon's Certificate No. A 39696** Respondent.	Case No. 800-2016-024668 OAH No. 2019100622 **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. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

2. Respondent Alan Ogden Marcus, M.D., is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about April 11, 1983, the Board issued Physician's and Surgeon's Certificate No. A 39696 to Alan Ogden Marcus, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-024668, and will expire on April 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-024668 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 August 23, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-024668 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. 800-2016-024668. Respondent has also carefully read, fully discussed with 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. 800-2016-024668, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

11. 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 Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2016-024668 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.

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

14. 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.

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15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 39696 issued to Respondent Alan Ogden Marcus, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of 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 indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

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

Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course 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 course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the course, or no later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course 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 medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the course, or no later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program no later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program no later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the program or no later than 15 calendar days after the effective date of the Decision, whichever is later.

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10

calendar days after the end of the preceding quarter.

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

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

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

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

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

Respondent shall submit quarterly declarations no later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) no later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

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

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ACCEPTANCE

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

DATED: 3/10/2020

ALAN OGDEN MARCUS, M.D.
Respondent

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

DATED: 3/11/2020

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 3/11/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-024668

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Alan Ogden Marcus, M.D.** 24422 Avenida De La Carlota, Suite 375 Laguna Hills, CA 92653 **Physician's and Surgeon's Certificate No. A 39696,** Respondent.	Case No. 800-2016-024668 **ACCUSATION**

PARTIES

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

2. On or about April 11, 1983, the Medical Board issued Physician's and Surgeon's Certificate No. A 39696 to Alan Ogden Marcus, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(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.

". . . ."

6. Section 725 of the Code states:

"(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."

7. Section 2266 of the Code states:

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

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

9. **Ativan,** the trade name for lorazepam, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures.

10. **Diazepam,** known by the trade name Valium, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon

abrupt discontinuance. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

11. **Fentanyl** (Actiq, Fentora, and Duragesic) is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication ordinarily used to treat patients with severe pain, especially after surgery. When properly prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant patients, severe enough to require daily, continuous, long term opioid treatment, and for which alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. The FDA has issued several black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants. Fentanyl comes in several forms, including as an injection, intrathecal administration (an injection around the spinal canal), a transdermal patch that is placed on the skin, or as a lozenge that is sucked like a cough drop (Actiq).

12. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning

being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

13. **MS Contin** (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified MS Contin, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress.

14. **Oxycodone with acetaminophen** (Percocet), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

15. **Oxycodone HCL** (OxyContin) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, OxyContin is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The DEA has identified OxyContin as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011

Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

16. **Provigil** (modafinil), a stimulant, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, or shift work disorder.

17. **Temazepam** (Restoril), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Restoril with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Restoril, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

18. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, D, E, and F, as more particularly alleged hereinafter:

PATIENT A

20. Respondent began treatment with Patient A,[1] a then-19-year old female, on or about February 20, 2014. The patient presented with numerous medical conditions, including hypopituitary and hypoadrenal issues, polycystic ovarian syndrome, thyroid disease, and autoimmune diseases.

21. On or about May 28, 2014, Respondent began prescribing Vicodin (325 mg acetaminophen/5 mg hydrocodone) to Patient A on a monthly basis. The dosage of Vicodin increased to 325/10 mg on or about August 25, 2014. While regularly prescribing Vicodin, Respondent also began prescribing Percocet (325 mg acetaminophen/5 mg oxycodone) on or about September 3, 2014. Between approximately September 25, 2014 and November 18, 2014, Respondent concurrently issued prescriptions for numerous opioids and benzodiazepines, including Percocet,[2] Vicodin, OxyContin, Fentanyl, lorazepam,[3] zolpidem, and diazepam. During this time, Respondent had no formal training in pain management,[4] and prescribed multiple opioids concurrently with benzodiazepines without documenting the following: a specific diagnosis for which opiate treatment was required, informed consent, a treatment plan with objectives, periodic reviews, referral to a specialist when indicated, and monitoring of patient compliance with the prescribed medication.

22. On or about October 29, 2014, Respondent prescribed Fentanyl patches without documenting a diagnosis or treatment plan. On or about October 8, 2014, Respondent prescribed Oxycodone with only a reference to "LS Cervical pain" in the notes, and without documenting a physical examination or future treatment plan. On or about May 19, 2015, Respondent prescribed Ativan with no clear diagnosis or treatment plan. On or about July 30, 2015, Respondent

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[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

[2] Three Percocet prescriptions for 305 total tablets during this time period.

[3] Two Ativan prescriptions for 100 total tablets during this time period.

[4] Respondent's only formal training in pain management did not occur until the spring of 2018 according to an interview conducted on March 19, 2019.

prescribed OxyContin 60 mg/day at the same time Patient A was receiving regular prescriptions for benzodiazepines.

23. In an interview on or about March 19, 2019, Respondent indicated that he only prescribed pain medicine to Patient A after consulting with and at the request of another physician, but there lacks any documentation to that effect. Respondent admitted that long-term opiate patients require a higher level of care, however, he failed to refer Patient A to an appropriate pain or addiction specialist during the course of treatment. During Respondent's care of Patient A from 2014 through 2017, Respondent did not use an electronic medical records system. His typical medical note was a single page of handwritten words that were largely illegible, and diagnoses and treatment plans were not readily apparent.

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

(a) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(b) Respondent failed to obtain informed consent for opiate therapy and the concurrent use of opioids with benzodiazepines;

(c) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(d) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(e) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(f) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(g) Respondent failed to record adequate and clear medical documentation.

PATIENT B

25. Respondent started treating Patient B, a then-60-year old male, in approximately June 2003.[5] The patient presented with a history of diabetes, lymphoma, thyroid disease, surgically repaired hand trauma, coronary artery disease, as well as other medical conditions. At his initial office visit, Patient B was under the case of three separate pain management physicians and several other specialist physicians. Respondent assumed case for many of Patient B's medical conditions and began prescribing him with numerous opioid pain medications.

26. Respondent prescribed numerus long-term opioids to Patient B concurrently with benzodiazepines. During the time period from approximately November 2013 through April 2017, Respondent prescribed Patient B with the following controlled substances on a recurring monthly basis:[6] Norco, 325/10 mg (#360), OxyContin 40 mg (#60), and temazepam 15 mg (#30). During this time, Respondent failed to document the following: an indication for which opiate therapy was required, informed consent, a treatment plan with objectives, periodic reviews, and monitoring of patient compliance with the prescribed medication. On or about November 15, 2015, Respondent prescribed Norco and OxyContin to Patient B without any corresponding office note for that date.

27. In an interview on or about March 19, 2019, Respondent admitted that long-term opiate use in an elderly patient such as Patient B[7] could cause him to "die" or go into "respiratory depression." Respondent understood that patients receiving dosages above 90 morphine milligram equivalent (MME) have a higher risk of an adverse event. However, from approximately November 2013 through April 2017, Respondent prescribed Patient B well in excess of 200 MME on a daily basis. At no time during this period did Respondent refer Patient B to a pain or addiction specialist even though he had no formal training in pain management. In

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[5] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[6] At times, some prescriptions were issued at intervals shorter than one month and longer than one month.

[7] Patient B was 72-years-old in 2016, the same time he was being prescribed substantial doses of opioids and benzodiazepines concurrently.

approximately March 2017, Respondent prescribed 60 tablets of OxyContin 40 mg and 480 tablets of Norco 325/10 mg, which equates to 280 MME daily over the course of the month, over three times the MME amount that should have prompted consideration of referral to a specialist. This pattern of high dose opioid therapy occurred while Respondent was concurrently prescribing benzodiazepines, not ordering urine drug screenings, and not checking CURES reports.

28. During Respondent's care of Patient B from 2014 through 2017, Respondent did not use an electronic medical records system. His typical medical note was a single page of handwritten words or notations that were largely illegible, and diagnoses and treatment plans were not readily apparent.

29. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(b) Respondent failed to obtain informed consent for opiate therapy and the concurrent use of opioids with benzodiazepines;

(c) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(d) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(e) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(f) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(g) Respondent failed to record adequate and clear medical documentation.

PATIENT C

30. Respondent began treating Patient C, a then-63-year old female, in approximately June 2005. The patient had a history of SIADH,[8] psoriatic arthritis, chronic pulmonary disease, frozen shoulder, ruptured tendons, anemia, hypertension, glaucoma, hypothyroidism, myocarditis from Coxsackie infection, and immunological issues. During the time period from approximately August 2013 through February 2017, Respondent prescribed Patient C with significant doses of controlled substances on a recurring monthly basis,[9] including Norco 325/10 mg (#240) and Provigil 200 mg (#60). During this time, Respondent failed to document the following: a specific diagnosis for which opiate use was required, informed consent, a discussion of side effects, justification of dosage, a treatment plan with objectives, periodic reviews evaluating the effectiveness of the medication, referral to a specialist when indicated, and monitoring of patient compliance with the prescribed medication.

31. On or about February 22, 2017, Respondent prescribed Provigil 800 mg/day, however, there lacks any documentation from the office note on the same date regarding the use, indication, or rationale for prescribing that medication. The dosage for Provigil of 800 mg/day far exceeds the typical dosage of 200 mg/day, but there is no explanation for this excessive dosage in the medical note. Given Patient C's long-term, high dosage of Provigil, in conjunction with the long-term, high dosage of Norco (which included 80 mg per day of hydrocodone), Patient C's daily MME far exceeded the 90 MME dosage level that Respondent understood created a higher risk of an adverse event in patients, and should have prompted referral to a specialist. Moreover, Respondent had no formal training in pain management during this time.

32. During Respondent's care of Patient C from 2014 through 2017, Respondent did not use an electronic medical records system. His typical medical note was a single page of handwritten words or notations that were largely illegible, and diagnoses and treatment plans were not readily apparent.

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[8] Syndrome of inappropriate antidiuretic hormone secretion (SIADH).

[9] At times, some prescriptions were issued at intervals shorter than one month and longer than one month.

33. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(b) Respondent failed to obtain informed consent for opiate therapy;

(c) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(d) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(e) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(f) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(g) Respondent failed to record adequate and clear medical documentation.

PATIENT D

34. Respondent began treating Patient D, a then-43-year old female, in approximately 1997 for "multiple things that were going on," according to Respondent.[10] During the time period from approximately July 2013 through February 2017, Respondent prescribed Patient D with significant doses of controlled substances on a recurring monthly basis,[11] including OxyContin 80 mg (#90) and alprazolam 2 mg (#210). During this time, Respondent had no formal training in pain management and failed to document the following: a specific diagnosis for which opiate use

[10] Medical records were not located by Respondent for Patient D, but according to his March 19, 2019, interview, she was being treated for "multiple things."

[11] At times, some prescriptions were issued at intervals shorter than one month and longer than one month.

was required, informed consent, a discussion of side effects, justification of dosage, a treatment plan with objectives, periodic reviews evaluating the effectiveness of the medication, and monitoring of patient compliance with the prescribed medication.

35. Between approximately July 2013 and February 2017, Respondent at times prescribed opiates in the range of 360 MME, four times the amount that Respondent understood created a higher risk of an adverse event in patients. There was no documentation that Respondent attempted to wean Patient D from controlled substances, attempted alternative medications and therapies, or considered referral to a pain specialist. In Respondent's Board interview, he indicated that "I have voluminous charts on her," but he was unable to provide any medical records for Patient D.

36. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Respondent prescribed long term, high dose opiates and benzodiazepines concurrently while not being a pain specialist;

(b) Respondent failed to document an adequate history and physical examination;

(c) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(d) Respondent failed to obtain informed consent for opiate therapy and the concurrent use of opioids with benzodiazepines;

(e) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(f) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(g) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(h) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(i) Respondent failed to maintain and make available Patient D's medical records.

PATIENT E

37. Respondent's initial treatment with Patient E, a then-69-year old male, occurred since at least 2014. He suffered from diabetes, hypertension, gout, and obesity. During the time period from approximately December 2014 through October 2016, Respondent prescribed Patient E with significant doses of opioids on a recurring monthly basis,[12] including Norco 325/10 mg (#120) and MS Contin 100 mg (#90).[13] During this time, Respondent had no formal training in pain management and failed to document the following: a specific diagnosis for which opiate use was required, informed consent, a discussion of side effects, justification of dosage, a treatment plan with objectives, periodic reviews evaluating the effectiveness of the medication, referral to a specialist when indicated, and monitoring of patient compliance with the prescribed medication.

38. Between approximately December 2014 and October 2016, Respondent prescribed Patient E with opiates at a substantial level of approximately 360 MME, yet there is no documentation that Respondent referred the patient to a pain specialist. On or about March 2, 2015, Respondent issued a prescription for Norco, yet the corresponding office note lists only Patient E's name and date while the remainder of the form is left completely blank.

39. During Respondent's care of Patient E from 2014 through 2017, Respondent did not use an electronic medical records system. His typical medical note was a single page of handwritten words or notations that were largely illegible, and diagnoses and treatment plans were not readily apparent.

[12] At times, some prescriptions were issued at intervals shorter than one month and longer than one month.

[13] Between approximately December 2014 and October 2016, Respondent prescribed on average 40mg of hydrocodone and 300-400 mg of morphine to Patient E.

40. Respondent committed gross negligence in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(b) Respondent failed to obtain informed consent for opiate therapy;

(c) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(d) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(e) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(f) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(g) Respondent failed to record adequate and clear medical documentation.

PATIENT F

41. Respondent began treating Patient F, a then-51-year old female, since at least 2013. She had a history of diabetes, depression, vaginal dryness, hepatitis C, and migraine headaches. During the time period from approximately December 2013 through January 2017, Respondent prescribed Patient F with substantial doses of opioids and benzodiazepines on a recurring monthly basis,[14] including Vicodin 325/7.5 mg and alprazolam.[15] During this time, Respondent had no formal training in pain management and failed to document the following: a specific diagnosis for

[14] At times, some prescriptions were issued at intervals shorter than one month and longer than one month.

[15] Prescriptions for alprazolam were initially prescribed for 0.5 mg in 2013 until on or about March 4, 2015, at which time the dosage permanently increased to 2 mg.

which opiate use was required, informed consent, a discussion of side effects, justification of dosage, a treatment plan with objectives, periodic reviews evaluating the effectiveness of the medication, referral to a specialist when indicated, attempts to wean controlled substances, and monitoring of patient compliance with the prescribed medication.

42. During Respondent's care of Patient F from 2014 through 2017, Respondent did not use an electronic medical records system. His typical medical note was a single page of handwritten words or notations that were largely illegible, and diagnoses and treatment plans were not readily apparent.

43. Respondent committed gross negligence in his care and treatment of Patient F which included, but was not limited to, the following:

(a) Respondent failed to establish a clear diagnosis for which opiate usage was required;

(b) Respondent failed to obtain informed consent for opiate therapy and the concurrent use of opioids with benzodiazepines;

(c) Respondent failed to document a detailed treatment plan with objectives and aims to be achieved when starting or continuing opioid therapy;

(d) Respondent failed to document formal periodic reviews detailing the safety and efficacy of treatment with opioid medication;

(e) Respondent did not take appropriate steps to monitor for medication compliance, such as random urine screens, blood samples, review of CURES, updated history and physical examination;

(f) Respondent failed to timely refer the patient to an appropriate pain specialist; and

(g) Respondent failed to record adequate and clear medical documentation.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, D, E, and F, as more particularly alleged in paragraphs 19 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

45. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to patients A, B, C, D, E, and F, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 19 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

46. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of patients A, B, C, D, E, and F, as more particularly alleged in paragraphs 19 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

47. To determine the degree of discipline, if any, to be imposed on Respondent Alan Ogden Marcus, M.D., Complainant alleges that on or about February 28, 2014, in a prior disciplinary action entitled *In the Matter of the Accusation Against Alan Ogden Marcus, M.D.*, before the Medical Board of California, in Case No. 04-2011-214937, Respondent's license was placed on probation for three years with terms and conditions for the following:

(1) Unprofessional Conduct; and (2) Dangerous Use of Drugs. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 39696, issued to Alan Ogden Marcus, M.D.;

2. Revoking, suspending or denying approval of Alan Ogden Marcus, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Alan Ogden Marcus, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: August 23, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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