XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
GIOVANNI F. MEJIA
Deputy Attorney General
State Bar No. 309951
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9072
Facsimile: (619) 645-2061

*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against: | Case No. 800-2017-030714 |
| **MARCO ANTONIO CHAVEZ, M.D.**<br>**1855 1st Avenue, Suite 200 B**<br>**San Diego, CA 92101-2685** | **DEFAULT DECISION AND ORDER** |
| **Physician's and Surgeon's Certificate No. A 115932,** | [Gov. Code, §11520] |
| Respondent. | |

## FINDINGS OF FACT

1. On or about January 21, 2020, the executive director of the Medical Board of California, Department of Consumer Affairs (Complainant), at the time Christine J. Lally serving in her official capacity as Interim Executive Director, filed Accusation No. 800-2017-030714 against Respondent Marco Antonio Chavez, M.D. (Respondent) before the Board.[1]

2. On or about February 25, 2011, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 115932 to Respondent. The Physician's and Surgeon's Certificate expired on June 30, 2018, and has not been renewed. A Certificate of

[1] Effective June 15, 2020, William Prasifka was appointed Executive Director of the Medical Board of California.

Licensure for Respondent, including his address of record with the Board, is included in the accompanying *Evidence Packet in Support of Default Decision and Order* (*Evidence Packet*) as Exhibit (Exh.) A, which is hereby incorporated by reference.

3. On or about January 21, 2020, an employee of the Board, served by certified mail a copy of the Accusation No. 800-2017-030714, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 1855 1st Avenue, Suite 200 B, San Diego, CA 92101-2685. On the same date, copies of the same documents were also served by certified mail to an address in Texas believed to have been associated with Respondent (the Texas Address). The Accusation, the related documents, and Declaration of Service are included in the accompanying *Evidence Packet* as Exh. B, which is hereby incorporated by reference.

4. The copies of Accusation No. 800-2017-030714, and the accompanying documents described in the Findings of Fact in paragraph 3, above, served on Respondent via certified mail to Respondent's address of record with the Board and the Texas Address were each returned to the Board by the U.S. Postal Service (USPS) respectively labelled "RETURN TO SENDER[,] INSUFFICIENT ADDRESS[,] UNABLE TO FORWARD" and "RETURN TO SENDER[,] UNCLAIMED[,] UNABLE TO FORWARD[,] RETURN TO SENDER[.]" The returned envelopes and enclosed documents are included in the accompanying *Evidence Packet* as Exh. C.

5. On or about February 24, 2020, counsel for Complainant spoke via telephone with Respondent's attorney of record in the case entitled *United States of America v. Marco Antonio Chavez,* U.S. District Court, Southern District of California, Case No. 18CR2930L. Respondent's attorney of record in that matter confirmed that his scope of representation of Respondent does not include the instant accusation matter, but provided an email address he believed to be associated with Respondent. (Declaration of Deputy Attorney General Giovanni F. Mejia [DAG Mejia Decl.], ¶ 5, included in the accompanying *Evidence Packet* as Exh. D.)

6. On or about March 3, 2020, Complainant served copies of a Courtesy Notice of Default on Respondent via first-class and certified mail to his address of record with the Board and the Texas address. The Courtesy Notice of Default included, without limitation, a copy of

Accusation No. 800-2017-030714 and the Notice of Defense form, as described in the Findings of Fact in paragraph 3, above. The Courtesy Notice of Default is included in the *Evidence Packet* as Exh. E, which is hereby incorporated by reference.

7. On or about March 4, 2020, counsel for Complainant sent a true and correct copy of the Courtesy Notice of Default to Respondent via email to the email address provided by Respondent's attorney of record in the case entitled *United States of America v. Marco Antonio Chavez,* U.S. District Court, Southern District of California, Case No. 18CR2930L. (Exh. D, DAG Mejia Decl., ¶ 7.)

8. On or about March 19, 2020, counsel for Complainant received a telephone call from a person identifying herself as a child of the primary resident of the Texas Address. The caller stated Respondent does not reside at the Texas Address. (Exh. D, DAG Mejia Decl., ¶ 8.)

9. On or about March 16, 2020, the USPS returned the copy of the Courtesy Notice of Default served on Respondent via first-class mail to Respondent's address of record with the Board, with what appeared to be "no longer at this address[,] RTS" written on the envelope. On or about March 20, 2020, the USPS returned the copy of the Courtesy Notice of Default served to Respondent's address of record with the Board via certified mail, labelled "RETURN TO SENDER[,] INSUFFICIENT ADDRESS[,] UNABLE TO FORWARD[.]" The returned envelopes and enclosed documents for the copies of the Courtesy Notice of Default served on Respondent at his address of record with the Board are included in the *Evidence Packet* as Exh. F.

10. On or about April 16, 2020, the USPS returned the copy of the Courtesy Notice of Default served via certified mail to the Texas Address, labelled "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" The returned envelope and enclosed documents for the copy of the Courtesy Notice of Default served to the Texas Address via certified mail is included in the *Evidence Packet* as Exh. G.

11. Service of Accusation No. 800-2017-030714 was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

////

////

12. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing....

13. Respondent failed to file a Notice of Defense within 15 days after service upon him of Accusation No. 800-2017-030714, and therefore waived his right to a hearing on the merits of the Accusation. (Exh. D, DAG Mejia Decl., ¶¶ 1 through 4.)

14. To date, Respondent has failed to file *any* Notice of Defense to Accusation No. 800-2017-030714. (Exh. D, DAG Mejia Decl., ¶¶ 1 through 4.)

15. Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

16. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibits A through L in the accompanying *Evidence Packet*, finds that the charges and allegations in Accusation No. 800-2017-030714, and each of them, separately and severally, are true and correct.

17. Section 2227, subdivision (a) of the Business and Professions Code[2] states:

> 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.

[2] Unless noted otherwise, all code references hereinafter refer to the Business and Professions Code.

(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.

18. Business and Professions Code section 118, subdivision (b) states:

(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground.

19. 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....

20. Section 2239, subdivision (a) of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or

more than one misdemeanor or any felony involving the use, consumption, or self administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

21. Section 2280 of the Code states:

No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients. Violation of this section constitutes unprofessional conduct and is a misdemeanor.

22. Section 725, subdivision (a) of the Code states:

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.

23. Section 2242, subdivision (a) of the Code states, in pertinent part:

Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct....

24. 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."

25. Section 2021, subdivision (b) of the Code states:

Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

26. Section 2236 of the Code states, in pertinent part:

(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

...

(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

***Impaired Practice and Interactions with Board Investigators***

27. On or about April 18, 2018, Investigator S.B. (Inv. S.B.) of the State of California, Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU) presented to Respondent's address of record with the Board, 1855 1st Avenue, Suite 200 B, San Diego, CA 92101-2685 (the Office). (Declaration of HQIU Investigator S.B. [Inv. S.B. Decl.], ¶¶ 4 and 6, a true and correct copy of which is included in the accompanying *Evidence Packet* as Exh. H.)

28. At approximately 10:20 a.m., Respondent entered the waiting area where Inv. S.B. was present. Respondent addressed two other individuals in the waiting area, explaining to them that he would be with them in a few minutes. Inv. S.B. understood them to be patients of Respondent awaiting their appointments. Respondent escorted Inv. S.B. back to Respondent's office. (Exh. H, Inv. S.B. Decl., ¶ 7.)

29. Inv. S.B. observed Respondent walking very slowly and deliberately, and Respondent appeared to almost lose his balance multiple times. As he talked with Respondent, Inv. S.B. observed that Respondent's speech was slurred and very slow, and that Respondent appeared to think about his words very carefully. Inv. S.B. recognized such conduct as objective symptoms of alcohol intoxication based on Inv. S.B.'s training and experience as a sworn peace officer, including hundreds of encounters with individuals impaired due to alcohol intoxication. (Exh. H, Inv. S.B. Decl., ¶ 8.)

30. When Inv. S.B. and Respondent reached Respondent's office, Inv. S.B. observed that the office was in disarray. There were paintings on the floor and leaning against Respondent's desk and cabinets. Cleaning supplies were on the floor and there were numerous objects piled up in the corner behind Respondent's desk. There were also papers on the floor under the wheels of Respondent's chair. (Exh. H, Inv. S.B. Decl., ¶ 9.)

////

31. In Respondent's office, Inv. S.B. asked Respondent when he had last consumed an alcoholic beverage. Respondent stated that he had not had an alcoholic beverage since his parents arrived from Texas in February 2018. Respondent stated that he has no problems with alcohol and that he did not have any alcoholic beverages in his home or office. (Exh. H, Inv. S.B. Decl., ¶ 10.)

32. Inv. S.B. asked Respondent about the contents of various pieces of furniture in Respondent's office, including a night stand behind Respondent's desk. Respondent opened the top drawer of the night stand and Inv. S.B. observed a mostly empty 750 mL vodka bottle lying on its side on top of some papers. Respondent stared at the bottle for approximately ten seconds and then began mumbling. Inv. S.B. asked Respondent what type of alcohol was in the bottle and Respondent replied, "vodka." (Exh. H, Inv. S.B. Decl., ¶ 11.)

33. Inv. S.B. informed Respondent that he believed Respondent was so intoxicated that Respondent could not practice medicine safely. Respondent asked if he could notify his patients in the waiting area. Inv. S.B. followed Respondent to the waiting area, whereupon he observed Respondent inform two individuals Inv. S.B. understood to be patients that Respondent was sorry but he needed to reschedule their appointments. During the walk to the waiting area, Respondent continued to walk very slowly and deliberately, and also slightly lost his balance. (Exh. H, Inv. S.B. Decl., ¶ 12.)

34. Inv. S.B. then observed Respondent appearing to call patients to cancel his appointments for the rest of April 18, 2018, and the following two days (April 19, 2018, and April 20, 2018). (Exh. H, Inv. S.B. Decl., ¶ 13.)

35. Additional investigators from HQIU arrived at Respondent's office and Respondent stated that he had not consumed any alcoholic beverages. Inv. S.B. asked Respondent if he would voluntarily provide a urine sample, which he agreed to do. (Exh. H, Inv. S.B. Decl., ¶ 14.)

36. After providing Inv. S.B. a urine sample, Respondent stated that his mother had been giving him a Mexican home remedy to stop his drinking. Respondent stated that the remedy consists of a glass of vodka mixed with fresh cloves. Respondent indicated that he had consumed an approximately eight-ounce glass of the beverage at approximately 6:00 a.m., and another

////

approximately eight-ounce glass of the beverage at approximately 7:00 a.m. (Exh. H, Inv. S.B. Decl., ¶ 15.)

37. Respondent removed a tissue from one of his pants pockets, which contained some small dark brown clumps of powder and what appeared to be small twigs. Respondent stated that they were cloves and that he would chew on them during his work day in an attempt to not drink the vodka. (Exh. H, Inv. S.B. Decl., ¶ 16.)

38. Inv. S.B. asked Respondent why his mother was concerned about his drinking and making remedies to help Respondent stop. Respondent stated that a friend had invited him to an Alcoholics Anonymous meeting, and that Respondent had gone to the meeting, but that it was not for him. Respondent stated that he grew up in an era of binge drinking, that he binge drank before his parents arrived from Texas, and that he has a problem with binge drinking. (Exh. H, Inv. S.B. Decl., ¶ 17.)

39. Respondent also stated that he has been depressed but has not sought treatment. He stated that he has been taking approximately 600 mg of gabapentin three times a day along with Keppra. Respondent stated that he thinks he is being overdosed with gabapentin and had spoken with his physician about it. (Exh. H, Inv. S.B. Decl., ¶ 18.)

40. Officer D.B. of the San Diego Police Department (Officer B.) arrived at the Office. (Declaration of San Diego Police Department Officer D.B. [Officer B. Decl.], ¶ 2, a true and correct copy of which is included in the accompanying *Evidence Packet* as Exh. I; Exh. H, Inv. S.B. Decl., ¶ 19.)

41. Respondent voluntarily agreed to submit to a preliminary alcohol-screening (PAS) test, which would measure his blood alcohol concentration (BAC). Officer B. administered a PAS test on Respondent, which yielded a BAC of .216 percent. Approximately five minutes later, Officer B. again administered a PAS test on Respondent, which yielded a BAC of .201 percent. (Exh. I, Officer B. Decl., ¶¶ 3 through 5; Exh. H, Inv. S.B. Decl., ¶ 19.)

42. After the administration of the PAS tests, Respondent stated that he sees approximately six or seven patients a day. He stated that he had seen two patients on April 18, 2018 prior to meeting with Inv. S.B., and that he had issued a prescription to one of his

patients. Respondent further stated that he needs to get help with his drinking. (Exh. H, Inv. S.B. Decl., ¶ 20.)

43. Based on observations of objective symptoms of intoxication, Respondent's statements, and the PAS test results, the HQIU investigators determined that Respondent was a danger to himself and to others if allowed to continue to practice medicine. Respondent stated that he was closing his office for the rest of the week. Respondent appeared to close his office at approximately 12:40 p.m., and two individuals Inv. S.B. understood to be Respondent's mother and father arrived to pick up Respondent. (Exh. H, Inv. S.B. Decl., ¶ 21.)

44. The urine specimen provided by Respondent on or about April 18, 2018 later tested positive for the presence of alcohol and temazepam.[3] (Exh. H, Inv. S.B. Decl., ¶ 22.)

45. On or about April 30, 2018, Inv. S.B. and another HQIU investigator returned to the Office. During this visit, Respondent refused to provide a urine specimen for the performance of a urine drug screen. Respondent stated that his alcohol of choice is tequila, but that he was only drinking vodka prior to Inv. S.B.'s visit on or about April 18, 2018 as a home remedy to stop drinking. (Exh. H, Inv. S.B. Decl., ¶ 23.)

46. On or about May 7, 2018, an Ex Parte Interim Order of Suspension was issued by the Office of Administrative Hearings (OAH), immediately suspending Respondent's Physician's and Surgeon's Certificate No. A 115932, and prohibiting Respondent from practicing medicine in the State of California. On or about May 22, 2018, an Interim Suspension Order was issued by OAH leaving in full force and effect the prior ex parte order prohibiting Respondent from practicing medicine in the State of California. Respondent has remained suspended from the practice of medicine pending a final decision by the Board on an accusation. True and correct copies of OAH's Ex Parte Interim Order of Suspension dated May 7, 2018 and Interim Suspension Order dated May 22, 2018 are included in the accompanying *Evidence Packet* as Exh. J, which is hereby incorporated by reference as if fully set forth herein. (See also Exh. D, DAG Mejia Decl., ¶ 9.)

[3] Temazepam 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.

47. Subsequent to the Office of Administrative Hearings' issuance of the Interim Suspension Order issued on or about May 22, 2018, Inv. S.B. made numerous unsuccessful attempts to contact or locate Respondent. (Exh. H, Inv. S.B. Decl., ¶¶ 26 through 31.)

48. Efforts made by Inv. S.B. to contact or locate Respondent in or after May 2018 included, but were not limited to, telephone calls to multiple telephone numbers Inv. S.B. knew or believed to be associated with Respondent, and at least one email sent to an email address Inv. S.B. knew or believed to be associated with Respondent. Inv. S.B. received no response from Respondent to these communications. (Exh. H, Inv. S.B. Decl., ¶ 27.)

49. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included, but were not limited to, a visit to the Office on or about September 19, 2018. A worker stated to Inv. S.B. that Respondent had cleared out his office and left, and that the office space had been rented to another tenant. No forwarding address for Respondent was available. (Exh. H, Inv. S.B. Decl., ¶ 28.)

50. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included, but were not limited to, a visit to a residential address known to Inv. S.B. to have been a prior residence of Respondent. A construction worker at the residence stated to Inv. S.B. that Respondent no longer resided there and that the apartment was being remodeled for another tenant. (Exh. H, Inv. S.B. Decl., ¶ 29.)

51. On or about September 21, 2018, Inv. S.B. sent a written request to the United States Postal Service (USPS) requesting a forwarding address for Respondent. Inv. S.B. did not subsequently receive any forwarding address from the USPS. (Exh. H, Inv. S.B. Decl., ¶ 30.)

52. Respondent failed to timely notify the Board of his change of address and address of record following his departure from the Office. (See Exh. H, Inv. S.B. Decl., ¶¶ 26 through 31, 42 through 44, 48 through 50, 59 through 61, 69 through 71, 75 through 77, 83 through 85, 91 and 92.)

////

////

////

***Patient A***

53. In or around January 2017, "Patient A"[4] presented to Respondent for psychiatric care and treatment. During the appointment, Respondent gave Patient A one or more boxes of what Patient A understood to be sample medication. (See Exh. H, Inv. S.B. Decl., ¶¶ 32 and 33.)

54. When Patient A returned home after the appointment, he and his spouse found a small, empty vodka bottle inside a medication sample box that Patient A had received from Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 34.)

***Patient B***

55. On multiple occasions in or around August 2017 to May 2018, "Patient B" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 37.)

56. During one or more psychiatric appointments with Respondent in or around August 2017 to May 2018, Patient B observed Respondent exhibiting a sign or symptom of alcohol intoxication including, but not limited to, the smell of alcohol, a flushed face, red, blood shot or blurry eyes, impaired gait or stumbling, slurred speech, difficulty focusing, unresponsiveness, or any combination thereof. (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 41.)

57. Subsequent to a psychiatric appointment with Respondent in or about May 2018, Patient B was unable to contact Respondent or determine Respondent's whereabouts. (See Exh. H, Inv. S.B. Decl., ¶¶ 35 through 40.)

58. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient B's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 42.)

59. On or about October 2, 2018, Inv. S.B. received the returned request for Patient B's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]" "NOT HERE" was hand-written on the return envelope. (Exh. H, Inv. S.B. Decl., ¶ 43.)

[4] Patient names were withheld in Accusation No. 800-2017-030714 and are withheld in the instant Default Decision & Order in the interests of preserving patient confidentiality.

60. On or about December 11, 2018, Inv. S.B. received the returned request for Patient B's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 44.)

***Patient C***

61. On multiple occasions in or around 2012[5] to March 2018, "Patient C" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 45 through 47.)

62. During one or more psychiatric appointments with Respondent in or around 2017 or 2018, Patient C observed Respondent exhibiting one or more objective signs of intoxication including, but not limited to, slurred speech, repeating statements, half-open eyes, attempting to give Patient C the same prescription multiple times and forgetting that it had already been provided, or any combination thereof. (See Exh. H, Inv. S.B. Decl., ¶¶ 45 through 47; see also Declaration of Steven A. Ornish, M.D. [Dr. Ornish Decl.], which is included in the accompanying *Evidence Packet* as Exh. K, ¶¶ 1 through 6, and 8,)

63. On or about October 19, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient C's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 48.)

64. On or about October 31, 2018, Inv. S.B. received the returned, undelivered request for Patient C's medical records that had been sent via certified mail to Respondent, addressed to the Office. (Exh. H, Inv. S.B. Decl., ¶ 49.)

65. On or about December 11, 2018, Inv. S.B. received the returned request for Patient C's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 50.)

////

////

[5] Any acts or omissions by Respondent found herein to have occurred more than seven years prior to the filing date of Accusation No. 800-2017-030714 do not serve as the basis for any disciplinary action by the Board, but rather are provided for informational purposes only.

***Patient D***

66. On multiple occasions in or around January 2013 to October 2017, "Patient D" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 51 through 54.)

67. During one or more medical appointments in or around January 2013 to October 2017, Respondent disclosed personal or business information to Patient D without a valid therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 12; Exh. H, Inv. S.B. Decl., ¶¶ 51 and 52.)

68. On one or more occasions during the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent requested that Patient D post a positive online review of Respondent's practice to promote his business. (See Exh. H, Inv. S.B. Decl., ¶¶ 51 and 52.)

69. On multiple occasions during the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent conducted a medication monitoring appointment for Patient D of insufficient duration, on multiple occasions spending as little as approximately two to five minutes with Patient D. (See Exh. K, Dr. Ornish Decl., ¶¶ 13 and 27; Exh. H, Inv. S.B. Decl., ¶¶ 51 and 52.)

70. On or about May 20, 2014, Patient D presented to Respondent. In his medical record note for this appointment, Respondent failed to adequately establish or document the presence or absence of medication side effects, or perform or document a mental status examination. Respondent also failed to adequately document the medications prescribed to Patient D. (See Exh. K, Dr. Ornish Decl., ¶¶ 14 and 15.)

71. Patient D presented to Respondent on or about July 28, 2015 and August 18, 2015. In his medical record notes for these appointments, Respondent documented symptoms of major depression including, but not limited to, a depressed mood, anxiety, poor sleep, irritability, anhedonia, and decreased energy and appetite. However, during these appointments Respondent failed to adequately take or document a history regarding the chronology and nature and extent of

////

Patient D's symptoms, or a history regarding past response to treatment for any previous episodes of major depression. (See Exh. K, Dr. Ornish Decl., ¶ 16.)

72. On or about July 28, 2015, Respondent prescribed approximately 30 mg per day of Dexedrine[6] to Patient D. Respondent failed to adequately document a basis for the prescribing of this medication or medication amount. (See Exh. K, Dr. Ornish Decl., ¶ 17.)

73. In or about September 2015, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that the patient was doing great and that she had no problems. Respondent failed to adequately obtain or document a history regarding the disposition of Patient D's previously noted symptoms of major depressive disorder with anxiety and panic attacks. (See Exh. K, Dr. Ornish Decl., ¶ 18.)

74. On or about June 27, 2016, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that Patient D had four to six symptoms of depression, as well as anxiety and panic attacks. However, Respondent failed to adequately take or document a history of the nature and extent of any such symptoms of depression. (See Exh. K, Dr. Ornish Decl., ¶ 19.)

75. In his medical record note for the appointment with Patient D on or about June 27, 2016, Respondent documented Xanax[7] was one of Patient D's current medications but documented issuing a refill for another benzodiazepine, Klonopin.[8] (Exh. K, Dr. Ornish Decl., ¶ 20.)

76. On or about October 18, 2016, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that Patient D was doing well, had no problems and was just there for refills. Respondent failed to adequately obtain or document an

---

[6] Dexedrine, a brand name for dextroamphetamine, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Xanax, a brand name for alprazolam, 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. It is an anti-anxiety medication in the benzodiazepine family.

[8] Klonopin, a brand name for clonazepam, 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. It is an anti-anxiety medication in the benzodiazepine family.

interval history including, but not limited to, Patient D's response to treatment, or whether or how the previously reported symptoms of depression had resolved. (See Exh. K, Dr. Ornish Decl., ¶ 21.)

77. On at least one occasion in or around 2017, Respondent issued concurrent prescriptions for at least two benzodiazepines, Xanax and Klonopin, to Patient D. (Exh. K, Dr. Ornish Decl., ¶ 23.)

78. On or about September 6, 2017, Patient D presented to Respondent. In his medical record for this appointment, Respondent documented that he informed Patient D that he was terminating her as a patient. (Exh. K, Dr. Ornish Decl., ¶ 24.)

79. By letter dated October 2, 2017, Respondent notified Patient D that he had terminated her as a patient effective September 22, 2017. (Exh. K, Dr. Ornish Decl., ¶ 25.)

80. In terminating his medical care and treatment of Patient D, Respondent failed to provide Patient D prompt written notice of any availability of emergency treatment or access to services for a reasonable amount of time during which Patient D could arrange for care with a another healthcare provider. (See Exh. K, Dr. Ornish Decl., ¶ 26.)

81. Throughout the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent failed to properly treat Patient D's symptoms of major depression including, but not limited to, failing to adequately offer or administer psychotherapy or antidepressant treatment. (Exh. K, Dr. Ornish Decl., ¶ 22.)

***Patient E***

82. On multiple occasions in or around September 2013 to 2018, "Patient E" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 55 through 57.)

83. In or around 2017 or 2018, Respondent recommended to Patient E that, based at least in part on her medical condition, she take time off from work and apply for public benefits. (See Exh. H, Inv. S.B. Decl., ¶ 57.)

84. Patient E subsequently applied for public benefits and, as a part of the application process, requested on multiple occasions that Respondent provide a copy of her medical records. (See Exh. H, Inv. S.B. Decl., ¶ 57.)

85. Respondent failed to provide a copy of Patient E's medical records to Patient E or the public benefits program Patient E had applied to. (See Exh. H, Inv. S.B. Decl., ¶ 58.)

86. Following the issuance of the Interim Order of Suspension suspending Respondent's Physician's and Surgeon's Certificate No. A 115932, effective May 7, 2018, Patient E was unable to successfully contact Respondent or obtain a copy of medical records that had been maintained by Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 55.)

87. In or after May 2018, Respondent failed to take adequate steps to attempt to arrange for coverage or transition to a new treating psychiatrist after Respondent was unable to care for Patient E. (See Exh. K, Dr. Ornish Decl., ¶ 33.)

88. On or about January 31, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient E's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 59.)

89. On or about February 12, 2019, Inv. S.B. received the returned request for Patient E's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 60.)

90. On or about February 19, 2019, Inv. S.B. received the returned request for Patient E's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 61.)

***Patient F***

91. On multiple occasions in or around June 2015 to October 2017, "Patient F" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 62 through 65.)

92. On or about June 24, 2015, Respondent conducted an initial intake appointment with Patient F. During this initial intake appointment, Respondent failed to take or document an adequate psychiatric medical history for Patient F including, but not limited to, failing to adequately detail when Patient F commenced taking certain psychotropic medications, the history

////

and scope of Patient F's post-traumatic stress disorder (PTSD) symptoms, and Patient F's past response to psychotropic medications. (See Exh. K, Dr. Ornish Decl., ¶ 34.)

93. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented that Patient F had a prior suicide attempt, but failed to document the nature of the suicide attempt, the precipitant for it, or when it occurred. (See Exh. K, Dr. Ornish Decl., ¶ 35.)

94. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented that Patient F had a prior psychiatric hospitalization, but failed to adequately document details regarding this hospitalization including, but not limited to, where, when, why and for how long she was hospitalized, whether the hospitalization had any connection to the documented prior suicide attempt, or the nature of the treatment received during the hospitalization. (See Exh. K, Dr. Ornish Decl., ¶ 36.)

95. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented a statement to the effect that all of Patient F's psychotropic medications were increased, without adequate further details including, but not limited to, the new medication dosages, quantities or number of refills. (See Exh. K, Dr. Ornish Decl., ¶ 37.)

96. On or about August 5, 2015, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented panic attacks as a target symptom for Patient F for the first time. However, Respondent failed to adequately document details regarding the history of any such panic attacks including, but not limited to, the nature and extent of her purported panic attacks or response to treatment. (See Exh. K, Dr. Ornish Decl., ¶ 38.)

97. On or about November 9, 2015, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented that Patient F had been in a motor vehicle accident and that she had suffered a few scratches. However, Respondent failed to adequately inquire about or document details regarding the accident including, but not limited to, whether Patient F was the driver, sedation from Patient F's medications may have been a contributing factor, or Patient F had combined her medications with alcohol. (See Exh. K, Dr. Ornish Decl., ¶ 39.)

98. In his medical record for the appointment with Patient F on or about November 9, 2015, Respondent documented that he discontinued a Xanax prescription for Patient F and commenced a Klonopin prescription. However, Respondent failed to document a rationale for this change, the quantity of Klonopin dispensed or prescribed, or the number of refills provided. (See Exh. K, Dr. Ornish Decl., ¶ 40.)

99. On or about April 7, 2016, Patient F presented to Respondent. Respondent failed to adequately perform or document a mental status examination for this appointment. (See Exh. K, Dr. Ornish Decl., ¶ 41.)

100. On or about June 9, 2016, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented major depressive disorder (MDD) and generalized anxiety disorder (GAD) in addition to his prior working diagnosis of PTSD. However, Respondent failed to adequately document a rationale for adding MDD and GAD as working diagnoses. (Exh. K, Dr. Ornish Decl., ¶ 42.)

101. During an approximately two-month period in or around February 2, 2017 to March 31, 2017, the California Controlled Substance Utilization Review and Evaluation System (CURES) database lists the following prescriptions as having been issued by Respondent and filled by Patient F:

| Fill Date | Drug Name | Strength | Quantity | Days Supply |
|---|---|---|---|---|
| 2/2/2017 | Clonazepam | 1 MG | 60 | 15 |
| 2/2/2017 | Zolpidem Tartrate[9] | 10 MG | 30 | 30 |
| 2/9/2017 | Clonazepam | 1 MG | 60 | 30 |
| 2/9/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |
| 3/2/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |
| 3/2/2017 | Clonazepam | 1 MG | 60 | 15 |
| 3/13/2017 | Clonazepam | 1 MG | 60 | 30 |
| 3/13/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |

[9] Zolpidem, also known as Ambien, Ivadal, Stilnoct or Tilnox, 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.

| Fill Date | Drug Name | Strength | Quantity | Days Supply |
|---|---|---|---|---|
| 3/31/2017 | Clonazepam | 1 MG | 60 | 30 |
| 3/31/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |

(Exh. H, Inv. S.B. Decl., ¶ 66.)

102. During the approximately two-month period in or around February 2, 2017 to March 31, 2017, the clonazepam and zolpidem tartrate prescriptions filled to Patient F, per the CURES database, correspond to prescription dosages that are inconsistent with the dosages documented in Respondent's medical records for Patient F in or around the same period. (Exh. K, Dr. Ornish Decl., ¶ 43.)

103. On or about March 13, 2017, Respondent's office was contacted by a pharmacy regarding a request to fill a prescription issued by Respondent for sixty 1 mg tablets of clonazepam and thirty 10 mg tablets of zolpidem tartrate. Respondent's office approved the request, but Respondent's medical records for Patient F contain no adequate explanation why the filling of these prescriptions was approved. (See Exh. K, Dr. Ornish Decl., ¶ 44.)

104. Throughout the course of Respondent's care and treatment of Patient F in or around June 2016 to October 2017, Respondent failed to adequately review, or document adequate review of, the CURES database for controlled substance prescriptions issued to and filled by Patient F. (See Exh. K, Dr. Ornish Decl., ¶ 45.)

105. On one or more occasions in or around June 2015 to October 2017, Respondent conducted a medication monitoring appointment for Patient F of insufficient duration, on at least one occasion spending as little as approximately two minutes with Patient F. (See Exh. K, Dr. Ornish Decl., ¶¶ 46 and 48.)

106. On one or more occasions in or around June 2015 to October 2017, Respondent disclosed personal information regarding Respondent to Patient F during a medical appointment without a valid therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 47.)

////

////

////

***Patient G***

107. On multiple occasions in or around September 2015 to May 2018, "Patient G" presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 through 72.)

108. On or about May 31, 2018, Patient G presented to the Office for a scheduled appointment with Respondent. Upon or shortly after arrival, a purported receptionist for another physician stated to Patient G that Respondent and his staff had left the location weeks prior. The receptionist further stated that Respondent had not left a forwarding address and that Patient G would not be able to obtain a copy of her medical records. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 and 68.)

109. Respondent failed to take adequate steps to notify Patient G regarding the cessation of his practice at the Office. (See Exh. H, Inv. S.B. Decl., ¶¶ 67 and 68.)

110. On or about January 10, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient G's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 69.)

111. On or about January 22, 2019, Inv. S.B. received the returned request for Patient G's medical records that had been sent, via first-class mail, to Respondent addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 70.)

112. On or about January 28, 2019, Inv. S.B. received the returned, undelivered request for Patient G's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 71.)

***Patient H***

113. On multiple occasions in or around September 2016 to April 2018, Patient H presented to Respondent for psychiatric care and treatment. (See Exh. H, Inv. S.B. Decl., ¶¶ 73 through 78.)

////

114. In or around April 2018, Patient H presented to the Office for a scheduled appointment with Respondent. When Patient H arrived, he was told by a worker that Respondent had to cancel Patient H's appointment because of an emergency. Patient H received no information regarding a covering physician or referral to another treatment provider. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

115. Later that day and over the following days, Patient H made multiple attempts to contact Respondent by telephone, text message and email to discuss topics including, without limitation, rescheduling a medical appointment or difficulties that Patient H was experiencing tolerating one or more recently prescribed medications. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

116. On or about April 25, 2018, Patient H received an email from Respondent in which Respondent stated that he had suffered a seizure and that Respondent was doing his best to get back to his patients. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

117. Other than the email received on or about April 25, 2018, Patient H did not receive a response to his multiple communication attempts after the cancelled appointment in or around April 2018. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

118. Patient H received no written notification from Respondent regarding termination of care. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

119. Following the cancelled appointment with Respondent in or around April 2018, Patient H was unable to access any medical records maintained by Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 73.)

120. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient H's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 75.)

121. On or about October 2, 2018, Inv. S.B. received the returned request for Patient H's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 76.)

////

122. On or about December 11, 2018, Inv. S.B. received the returned request for Patient H's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 77.)

***Patient J***

123. On multiple occasions commencing in or around July 2017, "Patient J" presented to Respondent for medical care and treatment. (Exh. H, Inv. S.B. Decl., ¶¶ 79 through 86.)

124. On one or more occasions during a medical appointment in or after July 2017, Respondent disclosed personal or business-related information to Patient J without a valid therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶ 56 and 59.)

125. In or around June 2018, Patient J attempted to contact Respondent at multiple telephone numbers or email addresses that Patient J had known or reason to believe to be associated with Respondent. Patient J received no response from Respondent. (See Exh. H, Inv. S.B. Decl., ¶¶ 79 through 82.)

126. In or around June 2018, Patient J mailed a letter to Respondent requesting a copy of his medical records. Patient J received no response and was unable to obtain a copy of his medical records from Respondent. (See Exh. H, Inv. S.B. Decl., ¶ 79.)

127. On or about January 15, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient J's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 83.)

128. On or about January 29, 2019, Inv. S.B. received the returned request for Patient J's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 84.)

129. On or about February 5, 2019, Inv. S.B. received the returned, undelivered request for Patient J's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 85.)

***Patient K***

130. On multiple occasions in or around March 2017 to 2018, "Patient K" received medical care and treatment from Respondent. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 through 93.)

131. On one or more occasions in the course of Respondent's care and treatment of Patient K in or around March 2017 to 2018, Respondent cried or disclosed personal issues to Patient K during a medical appointment without a valid therapeutic reason for doing so. (See Exh. K, Dr. Ornish Decl., ¶¶ 60 and 61.)

132. On or about May 8, 2018, Patient K presented to Respondent for a medical appointment at the Office. Upon or shortly after arrival, Patient K observed a sign on a door stating, among other things, that Respondent would be out of the office and that all appointments were cancelled until further notice. The sign stated, "If you need refills please contact your Primary Care Doctor." The sign failed to include any forwarding or other contact information for Respondent. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 and 88.)

133. Patient K walked through the waiting area back toward Respondent's office. Patient K found Respondent in his office and observed him crying and packing his things. Respondent told Patient K that a staff person had stolen money from him and that the staff person had further gone to a governmental entity and complained that Respondent was seeing patients under the influence of alcohol. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 through 89.)

134. Subsequent to the May 2018 encounter with Respondent, Patient K found another healthcare provider. However, as late as December 2018, neither Patient K nor the subsequent healthcare provider were able to obtain a copy of Respondent's medical record for Patient K. (See Exh. H, Inv. S.B. Decl., ¶¶ 87 through 90.)

135. On or about December 17, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient K's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board. (Exh. H, Inv. S.B. Decl., ¶ 91.)

136. On or about December 31, 2018, Inv. S.B. received the returned requests for Patient K's medical records that had been sent, via first-class and certified mail, to Respondent

////

addressed to the Office. The return labels read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]" (Exh. H, Inv. S.B. Decl., ¶ 92.)

***Guilty Plea to Health Care Fraud***

137. On or about August 20, 2019, Respondent pleaded guilty to a felony violation of 18 U.S.C., § 1347 (Health Care Fraud) in the case entitled *United States of America v. Marco Antonio Chavez,* U.S. District Court, Southern District of California, Case No. 18CR2930L. True and correct copies of the Indictment, Plea Agreement, Findings and Recommendation of the Magistrate Judge Upon a Plea of Guilty, and Order adopting the Findings and Recommendation of the Magistrate Judge Upon a plea of Guilty in *United States of America v. Marco Antonio Chavez* are included in the *Evidence Packet* as Exh. L, which is hereby incorporated by reference. (See also Exh. D, DAG Mejia Decl., ¶ 10.)

**FIRST CAUSE FOR DISCIPLINE**

**(Use of Drugs or Alcoholic Beverages in a Manner, or to an Extent, as to be Dangerous to Himself, to Another Person, or to the Public)**

138. Respondent has subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2239, subdivision (a), of the Code, in that he used or prescribed, or administered to himself, drugs or alcoholic beverages to the extent, or in such manner, as to be dangerous or injurious to him, to another person, or to the public as more particularly described in the Findings of Fact in paragraphs 27 through 56, above, which are hereby incorporated by reference as if fully set forth herein.

**SECOND CAUSE FOR DISCIPLINE**

**(Practice of Medicine While Under the Influence of Any Narcotic Drug or Alcohol)**

139. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2280, of the Code, in that he practiced medicine while under the influence of any narcotic drug or alcohol to such an extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients, as more particularly described in the Findings of Fact in

////

paragraphs 27 through 56, above, which are hereby incorporated by reference as if fully set forth herein.

**THIRD CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

140. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in that he committed gross negligence in his care and treatment of one or more patients. The circumstances are as follows:

141. The Findings of Fact in paragraphs 47 through 52, and 61 through 136, above, are hereby incorporated by reference as if fully set forth herein.

142. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, failing to take adequate steps to provide Patient C or duly authorized third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 11.)

143. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to:

(a) Failing to maintain appropriate professional boundaries with Patient D.

(b) Conducting one or more medication management appointments of inadequate duration with Patient D.

(c) Failing to adequately document details regarding one or more prescriptions issued to Patient D including, but not limited to, the prescription name, quantity, dosage, clinical indication, or any combination thereof.

(d) Failing to document or maintain an adequate psychiatric history and record for Patient D.

(e) Failing to properly treat Patient D's symptoms of major depression.

(f) Concurrently prescribing more than one benzodiazepine to Patient D.

(See Exh. K, Dr. Ornish Decl., ¶ 27.)

////

////

144. Respondent committed gross negligence in his care and treatment of Patient E including, but not limited to, failing to adequately:

(a) Provide a copy of Patient E's medical records to Patient E or the public benefits program to which she had applied.

(b) Take steps to provide Patient E or duly authorized third parties access to medical records.

(c) Take steps to attempt to arrange coverage or a transition of care to another treating psychiatrist once Respondent was unable to provide care to Patient E.

(See Exh. K, Dr. Ornish Decl., ¶ 33.)

145. Respondent committed gross negligence in his care and treatment of Patient F including, but not limited to:

(a) Conducting one or more medication monitoring appointments of inadequate duration with Patient F.

(b) Failing to maintain appropriate professional boundaries with Patient F.

(c) Failing to adequately obtain or document details regarding Patient F's history of a suicide attempt and psychiatric hospitalization.

(d) Failing to adequately obtain or document details regarding Patient F's reported panic attacks.

(e) Failing to adequately document details regarding prescriptions issued to Patient F.

(f) Prescribing controlled substances to Patient F without establishing or documenting adequate medical indication.

(See Exh. K, Dr. Ornish Decl., ¶ 48.)

146. Respondent committed gross negligence in his care and treatment of Patient G including, but not limited to, failing to take adequate steps to provide Patient G or duly authorized third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 52.)

////

////

147. Respondent committed gross negligence in his care and treatment of Patient H including, but not limited to, failing to take adequate steps to provide Patient H or duly authorized third parties access to medical records. (See Exh. K, Dr. Ornish Decl., ¶ 55.)

148. Respondent committed gross negligence in his care and treatment of Patient J including, but not limited to, failing to adequately:

(a) Maintain professional boundaries with Patient J.

(b) Take steps to provide Patient J or duly authorized third parties access to medical records.

(See Exh. K, Dr. Ornish Decl., ¶ 59.)

149. Respondent committed gross negligence in his care and treatment of Patient K including, but not limited to, failing to adequately:

(a) Take steps to provide Patient K or duly authorized third parties access to medical records.

(b) Maintain professional boundaries with Patient K.

(See Exh. K, Dr. Ornish Decl., ¶ 64.)

**FOURTH CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

150. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (c) of the Code in that he committed repeated negligent acts in his care and treatment of one or more patients. The circumstances are as follows:

151. The Findings of Fact in paragraphs 47 through 52, 61 through 136, and 140 through 149, above, are hereby incorporated by reference as if fully set forth herein.

152. Respondent committed additional negligent acts in his care and treatment of Patient D including, but not limited to, failing to provide adequate notice to Patient D regarding termination of care. (See Exh. K, Dr. Ornish Decl., ¶ 28.)

////

////

153. Respondent committed additional negligent acts in his care and treatment of Patient F including, but not limited to, failing to adequately:

(a) Obtain or document a general psychiatric history during Patient F's initial intake appointment on or about June 24, 2015.

(b) Obtain or document details regarding Patient F's reported motor vehicle accident in or around November 2015.

(c) Document details regarding the change of Patient F's benzodiazepine prescription from Xanax to Klonopin in or about November 2015.

(d) Perform or document a mental status examination during Patient F's appointment on or about April 7, 2016.

(e) Document a rationale for changing the working diagnoses for Patient F on or about June 9, 2016.

(See Exh. K, Dr. Ornish Decl., ¶ 49.)

**FIFTH CAUSE FOR DISCIPLINE**

**(Excessive Prescribing)**

154. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment as more particularly described in the Findings of Fact in paragraphs 66 to 81, 91 to 106, 143, and 145, above, which are hereby incorporated by reference as if fully set forth herein. (See Exh. K, Dr. Ornish Decl., ¶¶ 29 and 50.)

**SIXTH CAUSE FOR DISCIPLINE**

**(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior Examination and a Medical Indication)**

155. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code in that he prescribed a dangerous drug without an appropriate prior

examination and a medical indication as more particularly described in the Findings of Fact in paragraphs 66 to 81, 91 to 106, 143, and 145, which are hereby incorporated by reference and realleged as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

156. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to the provision of services to his patients as more particularly described in the Findings of Fact in paragraphs 55 through 136 and 140 through 153, above, which are hereby incorporated by reference as if fully set forth herein.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Failure to Timely Report a Change of Address to the Board)**

157. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code in that he violated section 2021, subdivision (b) of the Code by failing to notify the Board of one or more changes of address within 30 days as more particularly described in the Findings of Fact in paragraphs 27 through 52, and 55 to 136, above, which are hereby incorporated by reference as if fully set forth herein.

**NINTH CAUSE FOR DISCIPLINE**

**(Conviction Related to the Qualifications, Functions or Duties of a Licensee)**

158. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of the Code in that he was convicted, by his plea of guilty, to an offense substantially related to the qualifications, functions or duties of a licensee as more particularly described in the Findings of Fact in paragraph 137, above, which is hereby incorporated by reference as if fully set forth herein.

////

## TENTH CAUSE FOR DISCIPLINE

**(Violating the Medical Practice Act)**

159. Respondent further has subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (a) in that he violated or attempted to violate, directly or indirectly, one or more provisions of the Medical Practice Act, as more particularly described in the Findings of Fact in paragraphs 27 through 158, above, which are hereby incorporated by reference as if fully set forth herein.

## DETERMINATION OF ISSUES

1. Pursuant to Government Code section 11520, the Board hereby takes action based upon Respondent's express admissions or upon other evidence contained in the accompanying *Evidence Packet* filed herewith.

2. Pursuant to its authority under Government Code section 11520, and based on the evidence before it, the Board hereby finds that the charges and allegations in Accusation No. 800-2017-030714, and the Findings of Fact in paragraphs 1 through 159, above, and each of them, severally and separately, are true and correct.

3. Pursuant to its authority under section 2227 of the Code and section 11520 of the Government Code, and based on the evidence before it, the Findings of Fact in paragraphs 1 through 159, above, and the Determinations of Issues 1 and 2, above, the Board hereby finds that Respondent Marco Antonio Chavez, M.D. has subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action in that:

(a) Respondent used drugs or alcoholic beverages in a manner, or to an extent, as to be dangerous to himself, to another person, or to the public, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 2239, subdivision (a) of the Code;

(b) Respondent engaged in the practice of medicine while under the influence of any narcotic drug or alcohol, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 2280 of the Code;

////

(c) Respondent committed gross negligence in the course of his care and treatment of one or more patients, which constitutes grounds for Board disciplinary action pursuant to section 2234, subdivision (b) of the Code;

(d) Respondent committed repeated negligent acts in the course of his care and treatment of one or more patients, which constitutes grounds for Board disciplinary action pursuant to section 2234, subdivision (c) of the Code;

(e) Respondent committed repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 725, subdivision (a) of the Code;

(f) Respondent prescribed a dangerous drug without an appropriate prior examination and a medical indication on one or more occasions, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 2242, subdivision (a) of the Code;

(g) Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 2266 of the Code;

(h) Respondent failed to notify the Board of one or more changes of address within 30 days, which constitutes grounds for Board disciplinary action pursuant to sections 2234, subdivision (a) and 2021, subdivision (b) of the Code;

(i) Respondent was convicted of an offense substantially related to the qualifications, functions or duties of a licensee, which constitutes grounds for Board disciplinary action pursuant to sections 2234 and 2236 of the Code; and

(j) Respondent violated or attempted to violate, directly or indirectly, one or more provisions of the Medical Practice Act, which constitutes grounds for Board disciplinary action pursuant to section 2234, subdivision (a) of the Code.

////

////

## ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. A 115932, heretofore issued to Respondent Marco Antonio Chavez, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective at 5:00 p.m. on JUL 23 2020.

It is so ORDERED JUN 23 2020

WILLIAM PRASIFKA
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
GIOVANNI F. MEJIA
Deputy Attorney General
State Bar No. 309951
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9072
Facsimile: (619) 645-2061

*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**Marco Antonio Chavez, M.D.**<br>**1855 1st Avenue, Suite 200 B**<br>**San Diego, CA 92101-2685**<br><br>**Physician's and Surgeon's Certificate No. A 115932,**<br><br>Respondent. | Case No. 800-2017-030714<br><br>**ACCUSATION** |

## PARTIES

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

2. On or about February 25, 2011, the Medical Board issued Physician's and Surgeon's Certificate No. A 115932 to Marco Antonio Chavez, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on June 30, 2018, and has not been renewed.

3. On or about May 7, 2018, an Ex Parte Interim Order of Suspension was issued by the Office of Administrative Hearings, immediately suspending Respondent's Physician's and

Surgeon's Certificate No. A 115932, and prohibiting respondent from practicing medicine in the State of California. On or about May 22, 2018, an Interim Suspension Order was issued by the Office of Administrative Hearings leaving in full force and effect the prior ex parte order prohibiting Respondent from practicing medicine in the State of California. Respondent remains suspended from the practice of medicine pending the issuance of a final decision after an administrative hearing on the Accusation.

**JURISDICTION**

4. 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.

5. 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.

6. 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....

7. Section 2239, subdivision (a) of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

8. Section 2280 of the Code states:

No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients. Violation of this section constitutes unprofessional conduct and is a misdemeanor.

9. Section 725, subdivision (a) of the Code states:

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.

10. Section 2242, subdivision (a) of the Code states, in pertinent part:

Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

/ / / /

11. 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."

12. Section 2021, subdivision (b) of the Code states:

> Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

13. Section 2236 of the Code states, in pertinent part:

> (a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.
>
> ...
>
> (d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

## FACTS

### *Impaired Practice and Other Interactions with Board Investigators*

14. On or about April 18, 2018, Investigator S.B. (Inv. S.B.) of the State of California, Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU) presented to Respondent's then address of record with the Board in or around San Diego, California (the Office).

15. At approximately 10:20 a.m., Respondent entered the waiting area where Inv. S.B. was present. Respondent addressed two other individuals in the waiting area, explaining to them that he would be with them in a few minutes. Inv. S.B. understood them to be patients of Respondent awaiting their appointments. Respondent escorted Inv. S.B. back to Respondent's office.

16. Inv. S.B. observed Respondent walking very slowly and deliberately, and Respondent appeared to almost lose his balance multiple times. As he talked with Respondent, Inv. S.B.

observed that Respondent's speech was slurred and very slow, and that Respondent appeared to think about his words very carefully. Inv. S.B. recognized such conduct as objective symptoms of alcohol intoxication based on Inv. S.B.'s training and experience as a sworn peace officer, including hundreds of encounters with individuals impaired due to alcohol intoxication.

17. When Inv. S.B. and Respondent reached Respondent's office, Inv. S.B. observed that the office was in disarray. There were paintings on the floor and leaning against Respondent's desk and cabinets. Cleaning supplies were on the floor and there were numerous objects piled up in the corner behind Respondent's desk. There were also papers on the floor under the wheels of Respondent's chair.

18. In Respondent's office, Inv. S.B. asked Respondent when he had last consumed an alcoholic beverage. Respondent stated that he had not had an alcoholic beverage since his parents arrived from Texas in February 2018. Respondent stated that he has no problems with alcohol and that he did not have any alcoholic beverages in his home or office.

19. Inv. S.B. asked Respondent about the contents of various pieces of furniture in Respondent's office, including a night stand behind Respondent's desk. Respondent opened the top drawer of the night stand and Inv. S.B. observed a mostly empty 750 mL vodka bottle lying on its side on top of some papers. Respondent stared at the bottle for approximately ten seconds and then began mumbling. Inv. S.B. asked Respondent what type of alcohol was in the bottle and Respondent replied, "vodka."

20. Inv. S.B. informed Respondent that he believed Respondent was so intoxicated that Respondent could not practice medicine safely. Respondent asked if he could notify his patients in the waiting area. Inv. S.B. followed Respondent to the waiting area, whereupon he observed Respondent inform two individuals Inv. S.B. understood to be patients that Respondent was sorry but he needed to reschedule their appointments. During the walk to the waiting area, Respondent continued to walk very slowly and deliberately, and also slightly lost his balance.

21. Inv. S.B. then observed Respondent appearing to call patients to cancel his appointments for the rest of April 18, 2018, and the following two days (April 19, 2018, and April 20, 2018).

22. Additional investigators from HQIU arrived at Respondent's office and Respondent stated that he had not consumed any alcoholic beverages. Inv. S.B. asked Respondent if he would voluntarily provide a urine sample, which he agreed to do.

23. After providing Inv. S.B. a urine sample, Respondent stated that his mother had been giving him a Mexican home remedy to stop his drinking. Respondent stated that the remedy consists of a glass of vodka mixed with fresh cloves. Respondent indicated that he had consumed an approximately eight-ounce glass of the beverage at approximately 6:00 a.m., and another approximately eight-ounce glass of the beverage at approximately 7:00 a.m.

24. Respondent removed a tissue from one of his pants pockets, which contained some small dark brown clumps of powder and what appeared to be small twigs. Respondent stated that they were cloves and that he would chew on them during his work day in an attempt to not drink the vodka.

25. Inv. S.B. again asked Respondent why his mother was concerned about his drinking and making remedies to help Respondent stop. Respondent stated that a friend had invited him to an Alcoholics Anonymous meeting, and that Respondent had gone to the meeting, but that it was not for him. Respondent stated that he grew up in an era of binge drinking, that he binge drank before his parents arrived from Texas, and that he has a problem with binge drinking.

26. Respondent also stated that he has been depressed but has not sought treatment. He stated that he has been taking approximately 600 mg of gabapentin three times a day along with Keppra. Respondent stated that he thinks he is being overdosed with gabapentin and had spoken with his physician about it.

27. Officer D.B. of the San Diego Police Department (Officer B.) arrived at the Office.

28. Respondent voluntarily agreed to submit to a preliminary alcohol-screening (PAS) test, which would measure his blood alcohol concentration (BAC). Officer B. administered a PAS test on Respondent, which yielded a BAC of .216 percent. Approximately five minutes later, Officer B. again administered a PAS test on Respondent, which yielded a BAC of .201 percent.

29. After the administration of the PAS tests, Respondent stated that he sees approximately six or seven patients a day. He stated that he had seen two patients on

April 18, 2018 prior to meeting with Inv. S.B., and that he had issued a prescription to one of his patients. Respondent further stated that he needs to get help with his drinking. Based on observations of objective symptoms of intoxication, Respondent's statements, and the PAS test results, the HQIU investigators determined that Respondent was a danger to himself and to others if allowed to continue to practice medicine. Respondent stated that he was closing his office for the rest of the week. Respondent appeared to close his office at approximately 12:40 p.m., and two individuals Inv. S.B. understood to be Respondent's mother and father arrived to pick up Respondent.

30. The urine specimen provided by Respondent on or about April 18, 2018 later tested positive for the presence of alcohol and temazepam.[1]

31. On or about April 30, 2018, Inv. S.B. and another HQIU investigator returned to the Office. During this visit, Respondent refused to provide a urine specimen for the performance of a urine drug screen. Respondent stated that his alcohol of choice is tequila, but that he was only drinking vodka prior to Inv. S.B.'s visit on or about April 18, 2018 as a home remedy to stop drinking.

32. Subsequent to the Office of Administrative Hearings' issuance of the Interim Suspension Order on or about May 22, 2018, Inv. S.B. made numerous unsuccessful attempts to contact or locate Respondent.

33. Efforts made by Inv. S.B. to contact or locate Respondent in or after May 2018 included, but were not limited to, telephone calls to multiple telephone numbers Inv. S.B. knew or believed to be associated with Respondent, and at least one email sent to an email address Inv. S.B. knew or believed to be associated with Respondent. Inv. S.B. received no response from Respondent to these communications.

34. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included, but were not limited to, a visit to the Office on or about September 19, 2018. A worker stated to

/ / / /

[1] Temazepam 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.

Inv. S.B. that Respondent had cleared out his office and left, and that the office space had been rented to another tenant. No forwarding address for Respondent was available.

35. Respondent failed to timely notify the Board of his change of address and address of record following his departure from the Office.

36. Efforts made by Inv. S.B. to contact or locate Respondent after May 2018 included, but were not limited to, a visit to a residential address known to Inv. S.B. to have been a prior residence of Respondent. A construction worker at the residence stated to Inv. S.B. that Respondent no longer resided there and that the apartment was being remodeled for another tenant.

37. On or about September 21, 2018, Inv. S.B. sent a written request to the United States Postal Service (USPS) requesting a forwarding address for Respondent. Inv. S.B. did not subsequently receive any forwarding address from the USPS.

***Patient A***

38. In or around January 2017, "Patient A"[2] presented to Respondent for psychiatric care and treatment. During the appointment, Respondent gave Patient A one or more boxes of what Patient A understood to be sample medication.

39. When Patient A returned home after the appointment, he and his spouse found a small, empty vodka bottle inside a medication sample box that Patient A had received from Respondent.

***Patient B***

40. On multiple occasions in or around August 2017 to May 2018, "Patient B" presented to Respondent for psychiatric care and treatment.

41. During one or more psychiatric appointments with Respondent in or around August 2017 to May 2018, Patient B observed Respondent exhibiting a sign or symptom of alcohol intoxication during a medical appointment including, but not limited to, the smell of

[2] Patient names are withheld in the instant accusation to preserve the confidentiality of patient medical information. The identity of any patient referenced in this Accusation is known to Respondent or will be disclosed upon Complainant's receipt of a duly issued request for discovery from Respondent.

alcohol, a flushed face, red, blood shot or blurry eyes, impaired gait or stumbling, slurred speech, difficulty focusing, unresponsiveness, or any combination thereof.

42. Subsequent to a psychiatric appointment with Respondent in or about May 2018, Patient B was unable to contact Respondent or determine Respondent's whereabouts.

43. Respondent failed to provide Patient B adequate notice of termination of care, physician referral, or other assistance transitioning care to another healthcare provider.

44. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient B's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

45. On or about October 2, 2018, Inv. S.B. received the returned request for Patient B's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]" "NOT HERE" was hand-written on the return envelope.

46. On or about December 11, 2018, Inv. S.B. received the returned request for Patient B's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient C***

47. On multiple occasions in or around 2012[3] to March 2018, "Patient C" presented to Respondent for psychiatric care and treatment.

48. During one or more psychiatric appointments with Respondent in or around 2017 or 2018, Patient C observed Respondent exhibiting one or more objective signs of intoxication including, but not limited to, slurred speech, repeating statements, half-open eyes, attempting to give Patient C the same prescription multiple times and forgetting that it had already been provided, or any combination thereof.

/ / / /

[3] Any acts or omissions by Respondent alleged herein to have occurred more than seven years prior to the filing date of the instant Accusation are not intended to serve as the basis for disciplinary action, but rather are provided for informational purposes only.

49. On or about October 19, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient C's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

50. On or about October 31, 2018, Inv. S.B. received the returned, undelivered request for Patient C's medical records that had been sent via certified mail to Respondent, addressed to the Office.

51. On or about December 11, 2018, Inv. S.B. received the returned request for Patient C's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient D***

52. On multiple occasions in or around January 2013 to October 2017, "Patient D" presented to Respondent for psychiatric care and treatment.

53. During one or more medical appointments in or around January 2013 to October 2017, Respondent disclosed personal or business information to Patient D without a valid therapeutic reason for doing so.

54. On one or more occasions during the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent requested that Patient D post a positive online review of Respondent's practice to promote his business.

55. On multiple occasions during the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent conducted a medication monitoring appointment for Patient D of insufficient duration, on multiple occasions spending as little as approximately two to five minutes with Patient D.

56. On or about May 20, 2014, Patient D presented to Respondent. In his medical record note for this appointment, Respondent failed to adequately establish or document the presence or absence of medication side effects, or perform or document a mental status examination. Respondent also failed to adequately document the medications prescribed to Patient D.

/ / / /

57. Patient D presented to Respondent on or about July 28, 2015 and August 18, 2015. In his medical record notes for these appointments, Respondent documented symptoms of major depression including, but not limited to, a depressed mood, anxiety, poor sleep, irritability, anhedonia, and decreased energy and appetite. However, during these appointments Respondent failed to adequately take or document a history regarding the chronology and nature and extent of Patient D's symptoms, or a history regarding past response to treatment for any previous episodes of major depression.

58. On or about July 28, 2015, Respondent prescribed approximately 30 mg per day of Dexedrine[4] to Patient D. Respondent failed to adequately document a basis for the prescribing of this medication or medication amount.

59. In or about September 2015, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that the patient was doing great and that she had no problems. Respondent failed to adequately obtain or document a history regarding the disposition of Patient D's previously noted symptoms of major depressive disorder with anxiety and panic attacks.

60. On or about June 27, 2016, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that Patient D had four to six symptoms of depression, as well as anxiety and panic attacks. However, Respondent failed to adequately take or document a history of the nature and extent of any such symptoms of depression.

61. In his medical record note for the appointment with Patient D on or about June 27, 2016, Respondent documented Xanax[5] was one of Patient D's current medications but documented issuing a refill for another benzodiazepine, Klonopin.[6]

---

[4] Dexedrine, a brand name for dextroamphetamine, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Xanax, a brand name for alprazolam, 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. It is an anti-anxiety medication in the benzodiazepine family.

[6] Klonopin, a brand name for clonazepam, 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. It is an anti-anxiety medication in the benzodiazepine family.

62. On or about October 18, 2016, Patient D presented to Respondent. In his medical record note for this appointment, Respondent documented that Patient D was doing well, had no problems and was just there for refills. Respondent failed to adequately obtain or document an interval history including, but not limited to, Patient D's response to treatment, or whether or how the previously reported symptoms of depression had resolved.

63. On at least one occasion in or around 2017, Respondent issued concurrent prescriptions for at least two benzodiazepines, Xanax and Klonopin, to Patient D.

64. On or about September 6, 2017, Patient D presented to Respondent. In his medical record for this appointment, Respondent documented that he informed Patient D that he was terminating her as a patient.

65. By letter dated October 2, 2017, Respondent notified Patient D that he had terminated her as a patient effective September 22, 2017.

66. In terminating his medical care and treatment of Patient D, Respondent failed to provide Patient D prompt written notice of any availability of emergency treatment or access to services for a reasonable amount of time during which Patient D could arrange for care with a another healthcare provider.

67. Throughout the course of Respondent's care and treatment of Patient D in or around January 2013 to October 2017, Respondent failed to properly treat Patient D's symptoms of major depression including, but not limited to, failing to adequately offer or administer psychotherapy or antidepressant treatment.

***Patient E***

68. On multiple occasions in or around September 2013 to 2018, "Patient E" presented to Respondent for psychiatric care and treatment.

69. In or around 2017 or 2018, Respondent recommended to Patient E that, based at least in part on her medical condition, she take time off from work and apply for public benefits.

70. Patient E subsequently applied for public benefits and, as a part of the application process, requested on multiple occasions that Respondent provide a copy of her medical records.

/ / / /

71. Respondent failed to provide a copy of Patient E's medical records to Patient E or the public benefits program Patient E had applied to.

72. Following the issuance of the Interim Order of Suspension suspending Respondent's Physician's and Surgeon's Certificate No. A 115932, effective May 7, 2018, Patient E was unable to successfully contact Respondent or obtain a copy of medical records that had been maintained by Respondent.

73. In or after May 2018, Respondent failed to take adequate steps to attempt to arrange for coverage or transition to a new treating psychiatrist after Respondent was unable to care for Patient E.

74. On or about January 31, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient E's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

75. On or about February 12, 2019, Inv. S.B. received the returned request for Patient E's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]"

76. On or about February 19, 2019, Inv. S.B. received the returned request for Patient E's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient F***

77. On multiple occasions in or around June 2015 to October 2017, "Patient F" presented to Respondent for psychiatric care and treatment.

78. On or about June 24, 2015, Respondent conducted an initial intake appointment with Patient F. During this initial intake appointment, Respondent failed to take or document an adequate psychiatric medical history for Patient F including, but not limited to, failing to adequately detail when Patient F commenced taking certain psychotropic medications, the history

/ / / /

and scope of Patient F's post-traumatic stress disorder (PTSD) symptoms, and Patient F's past response to psychotropic medications.

79. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented that Patient F had a prior suicide attempt, but failed to document the nature of the suicide attempt, the precipitant for it, or when it occurred.

80. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented that Patient F had a prior psychiatric hospitalization, but failed to adequately document details regarding this hospitalization including, but not limited to, where, when, why and for how long she was hospitalized, whether the hospitalization had any connection to the documented prior suicide attempt, or the nature of the treatment received during the hospitalization.

81. In his medical record note for the initial intake appointment on or about June 24, 2015, Respondent documented a statement to the effect that all of Patient F's psychotropic medications were increased, without adequate further details including, but not limited to, the new medication dosages, quantities or number of refills.

82. On or about August 5, 2015, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented panic attacks as a target symptom for Patient F for the first time. However, Respondent failed to adequately document details regarding the history of any such panic attacks including, but not limited to, the nature and extent of her purported panic attacks or response to treatment.

83. On or about November 9, 2015, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented that Patient F had been in a motor vehicle accident and that she had suffered a few scratches. However, Respondent failed to adequately inquire about or document details regarding the accident including, but not limited to, whether Patient F was the driver, sedation from Patient F's medications may have been a contributing factor, or Patient F had combined her medications with alcohol.

84. In his medical record for the appointment with Patient F on or about November 9, 2015, Respondent documented that he discontinued a Xanax prescription for

Patient F and commenced a Klonopin prescription. However, Respondent failed to document a rationale for this change, the quantity of Klonopin dispensed or prescribed, or the number of refills provided.

85. On or about April 7, 2016, Patient F presented to Respondent. Respondent failed to adequately perform or document a mental status examination for this appointment.

86. On or about June 9, 2016, Patient F presented to Respondent. In his medical record for this appointment, Respondent documented major depressive disorder (MDD) and generalized anxiety disorder (GAD) in addition to his prior working diagnosis of PTSD. However, Respondent failed to adequately document a rationale for adding MDD and GAD as working diagnoses.

87. During an approximately two-month period in or around February 2, 2017 to March 31, 2017, the California Controlled Substance Utilization Review and Evaluation System (CURES) database lists the following prescriptions as having been issued by Respondent and filled by Patient F:

| Fill Date | Drug Name | Strength | Quantity | Days Supply |
|---|---|---|---|---|
| 2/2/2017 | Clonazepam | 1 MG | 60 | 15 |
| 2/2/2017 | Zolpidem Tartrate[7] | 10 MG | 30 | 30 |
| 2/9/2017 | Clonazepam | 1 MG | 60 | 30 |
| 2/9/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |
| 3/2/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |
| 3/2/2017 | Clonazepam | 1 MG | 60 | 15 |
| 3/13/2017 | Clonazepam | 1 MG | 60 | 30 |
| 3/13/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |
| 3/31/2017 | Clonazepam | 1 MG | 60 | 30 |
| 3/31/2017 | Zolpidem Tartrate | 10 MG | 30 | 30 |

88. During the approximately two-month period in or around February 2, 2017 to March 31, 2017, the clonazepam and zolpidem tartrate prescriptions filled to Patient F, per the

[7] Zolpidem, also known as Ambien, Ivadal, Stilnoct or Tilnox, 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.

CURES database, correspond to prescription dosages that are inconsistent with the dosages documented in Respondent's medical records for Patient F in or around the same period.

89. On or about March 13, 2017, Respondent's Office was contacted by a pharmacy regarding a request to fill a prescription issued by Respondent for sixty 1 mg tablets of clonazepam and thirty 10 mg tablets of zolpidem tartrate. Respondent's Office approved the request, but Respondent's medical records for Patient F contain no adequate explanation why the filling of these prescriptions was approved.

90. Throughout the course of Respondent's care and treatment of Patient F in or around June 2016 to October 2017, Respondent failed to adequately review, or document adequate review of, the CURES database for controlled substance prescriptions issued to and filled by Patient F.

91. On one or more occasions in or around June 2015 to October 2017, Respondent conducted a medication monitoring appointment for Patient F of insufficient duration, on at least one occasion spending as little as approximately two minutes with Patient F.

92. On one or more occasions in or around June 2015 to October 2017, Respondent disclosed personal information regarding Respondent to Patient F during a medical appointment without a valid therapeutic reason for doing so.

***Patient G***

93. On multiple occasions in or around September 2015 to May 2018, "Patient G" presented to Respondent for psychiatric care and treatment.

94. On or about May 31, 2018, Patient G presented to the Office for a scheduled appointment with Respondent. Upon or shortly after arrival, a purported receptionist for another physician stated to Patient G that Respondent and his staff had left the location weeks prior. The receptionist further stated that Respondent had not left a forwarding address and that Patient G would not be able to obtain a copy of her medical records.

95. Respondent failed to take adequate steps to notify Patient G regarding the cessation of his practice at the Office.

/ / / /

96. On or about January 10, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient G's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

97. On or about January 22, 2019, Inv. S.B. received the returned request for Patient G's medical records that had been sent, via first-class mail, to Respondent addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

98. On or about February 28, 2019, Inv. S.B. received the returned, undelivered request for Patient G's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient H***

99. On multiple occasions in or around September 2016 to April 2018, Patient H presented to Respondent for psychiatric care and treatment.

100. In or around April 2018, Patient H presented to the Office for a scheduled appointment with Respondent. When Patient H arrived, he was told by a worker that Respondent had to cancel Patient H's appointment because of an emergency. Patient H received no information regarding a covering physician or referral to another treatment provider.

101. Later that day and over the following days, Patient H made multiple attempts to contact Respondent by telephone, text message and e-mail to discuss topics including, without limitation, rescheduling a medical appointment or difficulties that Patient H was experiencing tolerating one or more recently prescribed medications.

102. On or about April 25, 2018, Patient H received an email from Respondent in which Respondent stated that he had suffered a seizure and that Respondent was doing his best to get back to his patients.

103. Other than the email received on or about April 25, 2018, Patient H did not receive a response to his multiple communication attempts after the cancelled appointment in or around April 2018.

104. Patient H received no written notification from Respondent regarding termination of care.

105. Following the cancelled appointment with Respondent in or around April 2018, Patient H was unable to access any medical records maintained by Respondent.

106. On or about September 25, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient H's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

107. On or about October 2, 2018, Inv. S.B. received the returned request for Patient H's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]"

108. On or about December 11, 2018, Inv. S.B. received the returned request for Patient H's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient J***

109. On multiple occasions commencing in or around July 2017, "Patient J" presented to Respondent for medical care and treatment.

110. On one or more occasions during a medical appointment in or after July 2017, Respondent disclosed personal or business-related information to Patient J without a valid therapeutic reason for doing so.

111. In or around June 2018, Patient J attempted to contact Respondent at multiple telephone numbers or email addresses that Patient J had known or reason to believe to be associated with Respondent. Patient J received no response from Respondent.

112. In or around June 2018, Patient J mailed a letter to Respondent requesting a copy of his medical records. Patient J received no response and was unable to obtain a copy of his medical records from Respondent.

/ / / /

113. On or about January 15, 2019, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient J's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

114. On or about January 29, 2019, Inv. S.B. received the returned request for Patient J's medical records that had been sent via first-class mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

115. On or about February 5, 2019, Inv. S.B. received the returned, undelivered request for Patient J's medical records that had been sent via certified mail to Respondent, addressed to the Office. The return label read, "RETURN TO SENDER[,] NOT DELIVERABLE AS ADDRESSED[,] UNABLE TO FORWARD[.]"

***Patient K***

116. On multiple occasions in or around March 2017 to 2018, "Patient K" received medical care and treatment from Respondent.

117. On one or more occasions in the course of Respondent's care and treatment of Patient K in or around March 2017 to 2018, Respondent cried or disclosed personal issues to Patient K during a medical appointment without a valid therapeutic reason for doing so.

118. On or about May 8, 2018, Patient K presented to Respondent for a medical appointment at the Office. Upon or shortly after arrival, Patient K observed a sign on a door stating, among other things, that Respondent would be out of the office and that all appointments were cancelled until further notice. The sign stated, "If you need refills please contact your Primary Care Doctor." The sign failed to include any forwarding or other contact information for Respondent.

119. Patient K walked through the waiting area back toward Respondent's office. Patient K found Respondent in his office and observed him crying and packing his things. Respondent told Patient K that a staff person had stolen money from him and that the staff person had further gone to a governmental entity and complained that Respondent was seeing patients under the influence of alcohol.

120. Subsequent to the May 2018 encounter with Respondent, Patient K found another healthcare provider. However, as late as December 2018, neither Patient K nor the subsequent healthcare provider were able to obtain a copy of Respondent's medical record for Patient K.

121. On or about December 17, 2018, Inv. S.B. sent, via first-class and certified mail, duly-authorized requests for Patient K's medical records to Respondent addressed to the Office, Respondent's then address of record with the Board.

122. On or about December 31, 2018, Inv. S.B. received the returned requests for Patient K's medical records that had been sent, via first-class and certified mail, to Respondent addressed to the Office. The return labels read, "RETURN TO SENDER[,] ATTEMPTED – NOT KNOWN[,] UNABLE TO FORWARD[.]"

***Guilty Plea to Health Care Fraud***

123. On or about August 20, 2019, Respondent pleaded guilty to a felony violation of 18 U.S.C., § 1347 (Health Care Fraud) in the case entitled *United States of America v. Marco Antonio Chavez,* U.S. District Court, Southern District of California, Case No. 18CR2930L.

**FIRST CAUSE FOR DISCIPLINE**

**(Use of Drugs or Alcoholic Beverages in a Manner, or to an Extent, as to be Dangerous to Himself, to Another Person, or to the Public)**

124. Respondent has subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2239, subdivision (a), of the Code, in that he used or prescribed, or administered to himself, drugs or alcoholic beverages to the extent, or in such manner, as to be dangerous or injurious to him, to another person, or to the public as more particularly alleged in paragraphs 14 to 51, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**SECOND CAUSE FOR DISCIPLINE**

**(Practice of Medicine While Under the Influence of Any Narcotic Drug or Alcohol)**

125. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2280, of the Code, in that he practiced medicine while under the influence of any narcotic drug or alcohol

to such an extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients, as more particularly alleged in paragraphs 14 to 51, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**THIRD CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

126. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (b) of the Code in that he committed gross negligence in his care and treatment of one or more patients. The circumstances are as follows:

127. Paragraphs 32 to 37 and 47 to 122, above, are hereby incorporated by reference and realleged as if fully set forth herein.

128. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, failing to take adequate steps to provide Patient C or duly authorized third parties access to medical records.

129. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to:

(a) Failing to maintain appropriate professional boundaries with Patient D.

(b) Conducting one or more medication management appointments of inadequate duration with Patient D.

(c) Failing to adequately document details regarding one or more prescriptions issued to Patient D including, but not limited to, the prescription name, quantity, dosage, clinical indication, or any combination thereof.

(d) Failing to document or maintain an adequate psychiatric history and record for Patient D.

(e) Failing to properly treat Patient D's symptoms of major depression.

(f) Concurrently prescribing more than one benzodiazepine to Patient D.

/ / / /

/ / / /

130. Respondent committed gross negligence in his care and treatment of Patient E including, but not limited to, failing to adequately:

(a) Provide a copy of Patient E's medical records to Patient E or the public benefits program to which she had applied.

(b) Take steps to provide Patient E or duly authorized third parties access to medical records.

(c) Take steps to attempt to arrange coverage or a transition of care to another treating psychiatrist once Respondent was unable to provide care to Patient E.

131. Respondent committed gross negligence in his care and treatment of Patient F including, but not limited to:

(a) Conducting one or more medication monitoring appointments of inadequate duration with Patient F.

(b) Failing to maintain appropriate professional boundaries with Patient F.

(c) Failing to adequately obtain or document details regarding Patient F's history of a suicide attempt and psychiatric hospitalization.

(d) Failing to adequately obtain or document details regarding Patient F's reported panic attacks.

(e) Failing to adequately document details regarding prescriptions issued to Patient F.

(f) Prescribing controlled substances to Patient F without establishing or documenting adequate medical indication.

132. Respondent committed gross negligence in his care and treatment of Patient G including, but not limited to, failing to take adequate steps to provide Patient G or duly authorized third parties access to medical records.

133. Respondent committed gross negligence in his care and treatment of Patient H including, but not limited to, failing to take adequate steps to provide Patient H or duly authorized third parties access to medical records.

/ / / /

134. Respondent committed gross negligence in his care and treatment of Patient J including, but not limited to, failing to adequately:

(a) Maintain professional boundaries with Patient J.

(b) Take steps to provide Patient J or duly authorized third parties access to medical records.

135. Respondent committed gross negligence in his care and treatment of Patient K including, but not limited to, failing to adequately:

(a) Take steps to provide Patient K or duly authorized third parties access to medical records.

(b) Maintain professional boundaries with Patient K.

**FOURTH CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

136. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (c) of the Code in that he committed repeated negligent acts in his care and treatment of one or more patients. The circumstances are as follows:

137. Paragraphs 32 to 37, 47 to 122, and 126 to 135, above, are hereby incorporated by reference and realleged as if fully set forth herein.

138. Respondent committed additional negligent acts in his care and treatment of Patient D including, but not limited to, failing to provide adequate notice to Patient D regarding termination of care.

139. Respondent committed additional negligent acts in his care and treatment of Patient F including, but not limited to, failing to adequately:

(a) Obtain or document a general psychiatric history during Patient F's initial intake appointment on or about June 24, 2015.

(b) Obtain or document details regarding Patient F's reported motor vehicle accident in or around November 2015.

/ / / /

(c) Document details regarding the change of Patient F's benzodiazepine prescription from Xanax to Klonopin in or about November 2015.

(d) Perform or document a mental status examination during Patient F's appointment on or about April 7, 2016.

(e) Document a rationale for changing the working diagnoses for Patient F on or about June 9, 2016.

**FIFTH CAUSE FOR DISCIPLINE**

**(Excessive Prescribing)**

140. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code in that he committed repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment as more particularly alleged in paragraphs 52 to 67, 77 to 92, 129, and 131, which are hereby incorporated by reference and realleged as if fully set forth herein.

**SIXTH CAUSE FOR DISCIPLINE**

**(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior Examination and a Medical Indication)**

141. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code in that he prescribed a dangerous drug without an appropriate prior examination and a medical indication as more particularly alleged in paragraphs 52 to 67, 77 to 92, 129, and 131, which are hereby incorporated by reference and realleged as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

142. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to the provision of

services to his patients as more particularly alleged in paragraphs 40 to 122 and 126 to 139, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Failure to Timely Report a Change of Address to the Board)**

143. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code in that he violated section 2021, subdivision (b) of the Code by failing to notify the Board of one or more changes of address within 30 days as more particularly alleged in paragraphs 33 to 37 and 40 to 122, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**NINTH CAUSE FOR DISCIPLINE**

**(Conviction Related to the Qualifications, Functions or Duties of a Licensee)**

144. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of the Code in that he was convicted, by his plea of guilty, to an offense substantially related to the qualifications, functions or duties of a licensee as more particularly alleged in paragraph 123, above, which is hereby incorporated by reference and realleged as if fully set forth herein.

**TENTH CAUSE FOR DISCIPLINE**

**(Violating the Medical Practice Act)**

145. Respondent further has subjected his Physician's and Surgeon's Certificate No. A 115932 to disciplinary action under sections 2227 and 2234, subdivision (a) in that he violated or attempted to violate, directly or indirectly, one or more provisions of the Medical Practice Act, as more particularly alleged in paragraphs 14 to 144, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

/ / / /

/ / / /

/ / / /

/ / / /

## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 115932, issued to Respondent Marco Antonio Chavez, M.D.;

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

3. Ordering Respondent Marco Antonio Chavez, 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: January 21, 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*