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

In the Matter of the Accusation Against: Michael Warren Nielsen, M.D. Physician's and Surgeon's Certificate No. A 79412 Respondent.	Case No.: 800-2017-037990

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 7, 2022.

IT IS SO ORDERED: December 8, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
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ALEXANDRA M. ALVAREZ
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MICHAEL WARREN NIELSEN, M.D.** **5872 La Jolla Corona Drive** **La Jolla, CA 92037-7446** **Physician's and Surgeon's Certificate No. A 79412,** Respondent.	Case No. 800-2017-037990 OAH No. 2020120687 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rosemary F. Luzon, Deputy Attorney General.

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2. Respondent Michael Warren Nielsen, M.D. (Respondent) is represented in this proceeding by attorney David Rosenberg, Esq., whose address is: Rosenberg, Shpall & Zeigen, APLC, 10815 Rancho Bernardo Road, Suite 310, San Diego, CA 92127.

3. On or about June 7, 2002, the Board issued Physician's and Surgeon's Certificate No. A 79412 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-037990, and will expire on April 30, 2022, unless renewed.

JURISDICTION

4. On or about October 19, 2020, Accusation No. 800-2017-037990 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about October 19, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2017-037990 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-037990. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2017-037990, and Respondent hereby gives up his right to contest those charges. Respondent further agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 79412 to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-037990 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 79412 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

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

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 79412 issued to Respondent Michael Warren Nielsen, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Decision on the following terms and conditions:

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

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

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

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

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

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

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

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

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4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s),

Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal

relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the

name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

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

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

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which

may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-037990 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David Rosenberg, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 79412. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8-20-2021

MICHAEL WARREN NIELSEN, M.D.
Respondent

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

DATED: 9/2/21

DAVID ROSENBERG, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: 9/3/21

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-037990

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Michael Warren Nielsen, M.D.** **5872 La Jolla Corona Drive** **La Jolla, CA 92037-7446** **Physician's and Surgeon's Certificate No. A 79412,** Respondent.	Case No. 800-2017-037990 **A C C U S A T I O N**

PARTIES

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

2. On or about June 7, 2002, the Medical Board issued Physician's and Surgeon's Certificate No. A 79412 to Michael Warren Nielsen, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2022, unless renewed.

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JURISDICTION

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

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

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.
>
> . . .

6. Section 2234 of the Code states:

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

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

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

. . .

7. Section 2266 of the Code states:

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

8. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79412 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:[1]

Patient A

10. On or about April 29, 2015, Patient A commenced treatment with Respondent as a new patient. Patient A expressed interest in testosterone[2] replacement therapy to improve his energy, libido, activity, mood, focus, and back pain management. In addition, Patient A stated that he was considering changing primary care physicians. Patient A's medical history included

[1] References to "Patient A," "Patient B," and "Patient C" herein are used to protect patient privacy.

[2] Testosterone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

chronic low back pain, hypertension, attention deficit hyperactivity disorder (ADHD), and insomnia. Patient A's medications included Percocet,[3] Valium,[4] Xanax,[5] Adderall,[6] and Ambien. During this visit, Patient A provided Respondent with a copy of a lab report dated October 9, 2013, when Patient A was under the care of another physician. The lab report showed a low total testosterone level of 288 ng/dL.[7] Respondent diagnosed Patient A with clinical hypogonadism. Respondent did not perform any testicular or prostate examination during the visit. Respondent did not order additional lab testing to confirm the low level of testosterone shown on the October 9, 2013, lab report. Respondent discussed testosterone replacement therapy and the potential side effects with Patient A, and Patient A signed the informed consent form. Respondent prescribed testosterone 200 mg/mL intramuscular (IM) injections to Patient A, to be administered on a weekly basis for 90 days. Respondent noted that he would "check [the] labs in 4-5 months."

11. On or about July 8, 2015, Patient A had a visit with Respondent to follow up on his testosterone therapy and transfer his primary care to Respondent. Respondent noted that Patient A was "doing well" with his testosterone therapy. Respondent continued Patient A on his regimen of testosterone 200 mg/mL weekly, and recommended that labs be performed. During the visit, Patient A also reported that he was experiencing worsening back pain and was taking up to six pills of Percocet 10 mg per day. Respondent noted that Patient A managed the pain "moderately well so far" with at-home physical therapy, opiate medications, and benzodiazepines as needed for muscle spasms. Respondent reviewed an MRI report of Patient A's lumbar spine dated January 15, 2014, and documented the pertinent findings of lumbar disc herniation,

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[3] Percocet (oxycodone and acetaminophen) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Valium (diazepam) 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.

[5] Xanax (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.

[6] Adderall (dextroamphetamine and amphetamine) 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] The normal reference range for total (or serum) testosterone levels is 348-1197 ng/dL.

radiculopathy, and spinal canal stenosis. Respondent performed a thorough musculoskeletal examination and recommended physical therapy. In addition, Respondent recommended that he continue his pain management with opiates and benzodiazepines as needed, since they allowed Patient A to perform daily life activities and to work. Respondent started Patient A on Percocet 5 mg tablets (#40) in order to assess the effectiveness of a lower dose. Respondent also discussed concerns about combining opiates and benzodiazepines with Patient A.

12. On or about July 17, 2015, Respondent placed an order for labs for Patient A. The results showed an excessively high serum testosterone level of 1457 ng/dL. The results also showed an abnormally high LDL cholesterol level of 146 mg/dL,[8] as well as increasing erythrocytosis.[9] Respondent did not see Patient A again until on or about October 12, 2015, and he did not make any changes to Patient A's testosterone therapy in the interim.

13. On or about October 12, 2015, Patient A had a follow-up visit with Respondent. Respondent noted that Patient A was "doing well" with his testosterone therapy, had no complaints, and reported improvements in his energy and libido. In addition, Respondent noted that the July 17, 2015, lab results showed a "marked increase in testosterone levels." Respondent reviewed the results with Patient A. Respondent continued Patient A on his regimen of testosterone 200 mg/mL weekly, and noted that labs should be repeated in "6 -12 months." Regarding Patient A's back pain, Respondent noted that Patient A was still unable to do most physical activities due to his back pain and required Percocet 10 mg, as much as six times a day, to manage the pain. Patient A reported trying Percocet 5 mg, but ended up having to take two pills at a time. He also reported using Xanax for muscle spasms with good relief, mostly at night at a frequency of less than one pill per day. Respondent noted that Patient A's back pain was not significantly worsening and he did not exhibit any red flags. He also noted that Patient A's use of Percocet 10 mg several times a day was necessary for him to work and perform daily life activities, that he had been on this dose for years without problems, and had no history of abuse,

[8] The normal reference range for LDL cholesterol levels is 0-99 ng/dL.

[9] Erythrocytosis refers to the increased production of red blood cells (erythrocytes).

addiction, or alcohol use. Respondent recommended that Patient A continue to manage his back pain with heat, NSAIDs, and physical therapy. Respondent continued Patient A on Percocet (#60) and increased the dosage from 5 mg to 10 mg. He noted that Patient A still had Xanax at home, and he discussed the side effects of using opiates and benzodiazepines together with Patient A.

14. On or about December 2, 2015, Patient A had a follow-up visit with Respondent. Patient A reported continued improvements in his "well being," sex drive, and energy. Respondent noted that Patient A was "doing well" with his testosterone therapy and continued him on his regimen of testosterone 200 mg/mL weekly. Patient A also reported that Xanax was not lasting long enough and that he was awoken by muscle spasms on some nights. Patient A described his back pain as getting "mildly worse," which he attributed to his increased activity level, but he otherwise reported no change in the character or quality of the pain. Respondent continued Patient A on Percocet 10 mg, and discussed addiction and alcohol avoidance with him. In addition, Respondent substituted Xanax with Valium 10 mg, due to its longer duration of therapy for muscle spasm relief, which he discussed with Patient A. He also prescribed Ambien 12.5 mg to Patient A.

15. On or about January 29, 2016, Patient A saw Respondent to refill his Adderall medication. Patient A showed Respondent an old prescription bottle and informed him that he had been taking Adderall for "many years . . . off and on," which his prior physician prescribed. Patient A also stated that while he had taken other medications in the past, Adderall worked best for him and had no significant side effects. Patient A asked Respondent to refill his Adderall since Patient A only wanted to see him for all of his medical issues. Respondent prescribed Adderall 20 mg, twice a day, to Patient A.

16. On or about February 10, 2016, Respondent placed an order for labs for Patient A. The results continued to show erythrocytosis with elevated hematocrit, an increased total cholesterol level of 238 mg/dL,[10] including a high LDL cholesterol level of 115 mg/dL, and an

[10] The normal reference range for total cholesterol levels is 100-199 mg/dL.

increased free testosterone level of 39.7 pg/mL.[11] Respondent continued Patient A on his regimen of testosterone 200 mg/mL weekly.

17. On or about March 24, 2016, April 15, 2016, and May 17, 2016, respectively, Patient A saw Respondent. During the March 24, 2016, and May 17, 2016 visits, Respondent recommended that Patient A go to a pain clinic for epidural spinal injections, but Patient A declined. During these visits, Respondent continued Patient A on Percocet and Valium, along with physical therapy. Respondent also continued Patient A on Adderall. During the April 15, 2016, visit, Respondent discussed trying a short-acting benzodiazepine again with Patient A, and he prescribed Xanax to Patient A. On or about May 17, 2016, Respondent noted that Patient A was using Valium and Xanax for muscle spasms, but not at the same time.

18. On or about June 15, 2016, Patient A saw Respondent to refill his pain medications and Adderall. Respondent noted that Patient A had been on testosterone therapy for approximately one year and was "doing well." Patient A reported that his pain was controlled with Percocet, but felt it was not as effective and had to take two pills at once sometimes. Respondent noted that he checked the CURES database and confirmed that no additional controlled medications were being prescribed to Patient A. Respondent prescribed Percocet 10 mg to Patient A, but increased the number of pills from #60 to #75. Respondent also prescribed Adderall to Patient A and renewed his testosterone prescription. Respondent noted that he placed an order for labs and reminded Patient A to get them done.

19. On or about July 15, 2016, Respondent placed an order for labs for Patient A. The results continued to show a high total testosterone level of 1575 ng/dL and a high total cholesterol level of 246 mg/dL, including a high LDL cholesterol level of 119 mg/dL. The results also showed a new finding of abnormal liver function test, with a high aspartate aminotransferase (AST) level of 195 IU/L.[12] Respondent continued Patient A on his regimen of testosterone 200 mg/mL weekly.

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[11] The normal reference range for free testosterone levels is 8.7-25.1 pg/mL.

[12] The AST test is a blood test that checks for liver damage. The normal reference range for AST levels is 0-40 IU/L.

20. On or about July 19, 2016, Patient A saw Respondent to refill his pain medications. Respondent noted that he reviewed the July 17, 2016, lab results with Patient A. Respondent did not document anything else regarding the lab results, including the abnormal findings.

21. Between on or about August 12, 2016, and December 6, 2016, Patient A saw Respondent on approximately four occasions. Patient A reported that his back pain was not improving and he had to take up to three Percocet pills a day on many days, but still had to miss work one day every two weeks due to pain. Respondent told Patient A that he should use a benzodiazepine as a muscle relaxer to decrease his pain, instead of increasing his Percocet use, and that he should not take both medications at the same time. Respondent continued Patient A on Percocet 10 mg, but increased the number of pills from #75 to #90. He also continued Patient A on Valium, Xanax, Adderall, and testosterone.

22. In or about 2017, Patient A saw Respondent on a monthly basis to refill his medications. On or about January 11, 2017, Patient A reported that he was taking three to four Percocet pills a day for pain and asked Respondent to increase the quantity of pills prescribed. Respondent told Patient A to first try more regular use of heat and his benzodiazepine medications before increasing his opiate medication.

23. On or about February 22, 2017, Respondent increased Patient A's Percocet 10 mg pills from #90 to #120. On or about April 6, 2017, Respondent again recommended that Patient A go to a pain clinic for epidural spinal injections. Respondent also discussed alterative pain medications such as tramadol with Patient A, but Patient A was not receptive. As of this visit, Patient A was taking Percocet 10 mg (#90). In addition, Patient A reported that Adderall was working well for him and, although he was not taking it every day as per Respondent's suggestion, he preferred to take it more consistently. Respondent encouraged Patient A to decrease his Adderall use. Respondent prescribed Adderall to Patient A, but lessened the dosage.

24. On or about June 29, 2017, Patient A continued to report worsening back pain, causing him to take four to five Percocet pills a day, use all of his Valium, and try acupuncture treatment without change. He inquired about taking both Valium and Xanax in the same day, for short acting relief during the day and long acting relief at night. He also asked Respondent to

increase his Percocet dosage to six pills per day. Respondent encouraged Patient A to continue with acupuncture and consider alternative pain relief therapy such as transcutaneous electrical nerve stimulation (TENS), which Patient A declined. Respondent increased Patient A's Percocet 10 mg pills from #90 to #120, advising him that four pills a day was the most he was comfortable prescribing to him. He also prescribed Valium, Xanax, and Adderall to Patient A. He discussed addiction and side effect risks with Patient A and cautioned him against using Valium and Xanax at the same time.

25. For the remainder of 2017, Respondent continued Patient A on Percocet 10 mg, ranging from #90 to #120 pills, as well as Valium and Xanax. He also continued Patient A on Adderall and testosterone, at his same regimen of 200 mg/mL weekly.

26. During the entirety of 2017, no labs were ordered or performed to monitor Patient A's testosterone therapy. In addition, between on or about January 29, 2016, and November 24, 2017, Respondent did not document Patient A's vital signs, including his blood pressure, history of present illness, or physical examination, with the exception of one visit, which took place on or about July 26, 2017.

27. On or about January 18, 2018, Patient A saw Respondent and reported elevated blood pressure during home monitoring. Respondent did not take Patient A's blood pressure during this visit. Respondent's diagnosis was mild hypertension and prescribed amlodipine 2.5 mg to Patient A. Patient A subsequently saw Respondent during near monthly visits, but Respondent did not take Patient A's blood pressure until on or about August 8, 2018.

28. On or about August 28, 2018, Respondent placed an order for labs for Patient A. The results showed a high free testosterone level of 30.4 pg/dL, a high AST level of 107 IU/L, and a high total cholesterol level of 344 mg/dL, with a high LDL cholesterol level of 281 mg/dL. Respondent did not document any assessment or discussion of the August 28, 2018, lab results in any subsequent visits with Patient A in 2018.

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29. Between on or about January 18, 2018, and December 27, 2018, Respondent continued Patient A on Percocet 10 mg (#120), Valium, Xanax, and Adderall. He also continued Patient A on his regimen of testosterone 200 mg/mL weekly. During this timeframe, Respondent did not document any vital signs, history of present illness, or physical examination of Patient A, except on the August 8, 2018 visit.

30. During Respondent's care and treatment of Patient A, between on or about April 29, 2015, and December 27, 2018, Respondent did not require Patient A to sign a pain management contract, did not order any urine toxicology testing, and did not perform any testicular or prostate examination of Patient A. In addition, Respondent's chart for Patient A did not include a signed copy of Patient A's HIPAA authorization form.

31. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but were not limited to the following:

A. Respondent improperly managed Patient A's testosterone replacement therapy by failing to clinically address the potential side effects of testosterone replacement therapy exhibited by Patient A, including abnormally high liver function tests and high cholesterol; and by failing to reduce Patient A's testosterone dosage despite abnormally high testosterone levels.

B. Respondent prescribed Adderall to Patient A on a chronic basis without confirming Patient A's ADHD diagnosis.

C. Respondent improperly managed Patient A's hypertension by failing to obtain regular blood pressure readings during Patient A's visits; and by failing to reduce, or consider reducing, Patient A's testosterone and Adderall dosages in response to Patient A's hypertension.

D. Respondent failed to recognize, evaluate, and address Patient A's abnormal liver function tests.

E. Respondent improperly managed Patient A's hyperlipidemia by failing to recognize, evaluate, and address Patient A's high cholesterol levels; by failing to reduce, or consider reducing, Patient A's testosterone dosage in response to Patient

A's hyperlipidemia; and by failing to start, or consider starting, Patient A on anti-cholesterol therapy.

F. Respondent improperly managed Patient A's chronic opiate therapy by failing to properly assess addiction risks prior to prescribing Percocet to Patient A; by failing to establish a multi-faceted pain management plan; by failing to have a pain management contract; and by failing to order any urine toxicology testing.

G. Respondent improperly prescribed benzodiazepines to Patient A by prescribing Valium and Xanax to Patient A simultaneously.

H. Respondent improperly prescribed opiates to Patient A by prescribing Percocet to Patient A concurrently with a benzodiazepine.

I. Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A by failing to regularly document Patient A's history of present illness, physical examinations, and vital signs, including Patient A's blood pressure levels; and by failing to maintain a signed copy of Patient A's HIPAA authorization form.

Patient B

32. On or about February 24, 2016, Patient B commenced treatment with Respondent for possible testosterone replacement therapy. Patient B complained of fatigue, decreased libido, and weight gain, and his health goals were weight loss, increased muscle mass and strength, and increased libido. Patient B told Respondent that he had done a previous lab test, which showed below normal total and free testosterone levels. Respondent documented that the lab results were notable for a total testosterone level of less than "300," a free testosterone level of less than "8," and an estradiol level of "30." The lab report was not included in Patient B's chart. Respondent did not document any additional information from the lab report, including the laboratory name, the test date, or other findings such as prostate-specific antigen (PSA),[13] liver function, or cholesterol values. Respondent diagnosed Patient B with clinical hypogonadism. Patient B

[13] The PSA test is a blood test used primarily to screen for prostate cancer.

declined a testicular and prostate examination during the visit. Respondent did not order additional lab testing to confirm Patient B's low testosterone levels. Respondent also did not order baseline lab testing to obtain complete blood count (CBC), PSA, lipid, and liver function values. Respondent discussed testosterone therapy with Patient B and its potential side effects, and Patient B signed the informed consent form. Respondent prescribed testosterone 200 mg/mL intramuscular (IM) injections to Patient B, to be administered once a week for 90 days. Respondent noted that he would "check [the] labs in 4-5 months."

33. On or about August 24, 2016, Patient B saw Respondent to follow up on his testosterone therapy. Patient B reported small improvements in his libido, energy, muscle mass, and morning erections. He also reported mild testicular shrinkage. No physical examination was done during this visit, including a testicular or prostate examination. Respondent reviewed the results of lab testing performed two days earlier, on or about August 22, 2016. The results showed normal total and free testosterone levels of 657 ng/dL and 15 pg/mL, respectively, as well as normal hemoglobin. PSA, liver panel, and cholesterol panel testing were not performed. Respondent noted that Patient B's testosterone levels had improved from pre-treatment levels, and Patient B expressed interest in increasing his testosterone dosage. Respondent continued Patient B on testosterone and increased his weekly testosterone dosage from 200 mg/mL to 240 mg/mL.

34. Respondent did not have a follow-up visit with Patient B until approximately one year later, on or about August 26, 2017. Respondent's chart did not include any notes reflecting any physical examinations of Patient B, lab testing, or any other contact with Patient B in the interim.

35. On or about August 26, 2017, Patient B was scheduled to see Respondent to follow up on his testosterone therapy, but Patient B was unable to make the office visit in person. Respondent conducted the follow-up visit by phone. Patient B reported that he was happy with his treatment and had no complaints. Respondent noted that there were no new labs for him to review and he encouraged Patient B to get follow-up labs done. Respondent also noted that he "reassured [Patient B] that treatment is based on symptom values versus lab results" and he "will

continue [the] treatment protocol despite no new labs[.]" Respondent continued Patient B on his regimen of testosterone 240 mg/mL weekly and told Patient B to have a follow-up visit with the clinic in "one year."

36. Between on or about July 25, 2017, and April 24, 2018, Patient B filled approximately four prescriptions of testosterone, which Respondent prescribed. With the exception of the August 26, 2017, encounter, Respondent did not have any follow-up visits with Patient B during this timeframe, and his chart did not include any notes reflecting any physical examinations of Patient B, lab testing, or any other contact with Patient B. In addition, Respondent's chart for Patient B did not include a signed copy of Patient B's HIPAA authorization form.

37. Respondent committed repeated negligent acts in his care and treatment of Patient B, which included, but were not limited to the following:

A. Respondent improperly managed Patient B's testosterone replacement therapy by failing to monitor treatment through office visits, physical examinations, and lab testing; and by increasing Patient B's testosterone weekly dosage beginning on or about August 24, 2016, despite normal testosterone levels.

B. Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient B by failing to document relevant lab values during the initial February 24, 2016, visit; by failing to have regular follow-up labs; and by failing to maintain a signed copy of Patient B's HIPAA authorization form.

Patient C

38. Between on or about November 7, 2016, and November 17, 2017, Patient C filled approximately 10 prescriptions of testosterone, which Respondent prescribed. For the prescriptions filled on or about November 7, 2016, December 17, 2016, January 24, 2017, March 1, 2017, April 11, 2017, June 7, 2017, and August 2, 2017, respectively, the prescribed dosage was 100 mg. For the prescriptions filled on or about August 28, 2017, October 12, 2017, and November 17, 2017, respectively, the prescribed dosage increased to 200 mg.

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39. On or about October 1, 2019, the office manager of Respondent's clinic certified that the clinic had no records pertaining to Patient C for the period of January 1, 2017, to December 1, 2018. In a letter dated on or about November 1, 2019, Respondent stated that a records search of current patients showed Patient C was not an active patient and that he also had no past medical records for Patient C. According to Respondent, these factors indicated that Patient C had not been under the care of his clinic within the past two years. During Respondent's interview with the Board, which took place on or about May 29, 2020, Respondent confirmed that he did not locate any medical records for Patient C. Respondent stated that Patient C was his patient and that he saw and treated him in his office. Respondent also stated that Patient C was a social and business acquaintance.

40. Respondent committed repeated negligent acts in his care and treatment of Patient C, which included, but were not limited to the following:

A. Respondent prescribed testosterone, a controlled substance, to Patient C, but he failed to retain any records regarding his care and treatment of Patient C.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

41. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79412 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 regarding his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 10 through 40, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

42. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79412 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 10 through 41, 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 79412, issued to Respondent Michael Warren Nielsen, M.D.;

2. Revoking, suspending or denying approval of Respondent Michael Warren Nielsen, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Michael Warren Nielsen, 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: OCT 19 2020

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

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