

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

In the Matter of the Accusation Against:

Richard Mark Goddard, M.D.

**Physician's and Surgeon's
Certificate No. G 67660**

Respondent.

Case No. 800-2021-081546


DECISION

The attached Stipulated Surrender of License 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 September 8, 2023.

IT IS SO ORDERED September 1, 2023.

MEDICAL BOARD OF CALIFORNIA



**Reji Varghese
Executive Director**

1 ROB BONTA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
Deputy Attorney General
4 State Bar No. 244388
California Department of Justice
5 1300 I Street, Suite 125
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8 *Attorneys for Complainant*

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

In the Matter of the Accusation Against:

Case No. 800-2021-081546

RICHARD MARK GODDARD, M.D.
225 N. Country Ln., Unit 78
St. George, UT 84770-8464

Physician's and Surgeon's Certificate
No. G 67660

**STIPULATED SURRENDER OF
LICENSE AND DISCIPLINARY ORDER**

Respondent.

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

PARTIES

22
23 1. Reji Varghese ("Complainant") is the Interim Executive Director of the Medical
24 Board of California ("Board"). He brought this action solely in his official capacity and is
25 represented in this matter by Rob Bonta, Attorney General of the State of California, by John S.
26 Gatschet, Deputy Attorney General.

27 2. Richard Mark Goddard, M.D. ("Respondent") is representing himself in this
28 proceeding and has chosen not to exercise his right to be represented by counsel.

1 seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical
2 Board, considers and acts upon it.

3 15. The parties agree that this Stipulated Surrender of License and Disciplinary Order
4 shall be null and void and not binding upon the parties unless approved and adopted by the
5 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
6 force and effect. Respondent fully understands and agrees that in deciding whether or not to
7 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
8 Director and/or the Board may receive oral and written communications from its staff and/or the
9 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
10 Executive Director, the Board, any member thereof, and/or any other person from future
11 participation in this or any other matter affecting or involving Respondent. In the event that the
12 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this
13 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
14 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
15 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
16 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
17 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
18 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
19 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
20 of any matter or matters related hereto.

21 **ADDITIONAL PROVISIONS**

22 16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
23 herein to be an integrated writing representing the complete, final and exclusive embodiment of
24 the agreements of the parties in the above-entitled matter.

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

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ACCEPTANCE

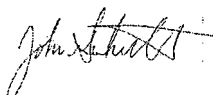
I have carefully read the Stipulated Surrender of License and Disciplinary Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6/10/2023 
RICHARD MARK GODDARD, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

June 12, 2023
DATED: _____

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

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-081546

1 ROB BONTA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
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10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
13 **STATE OF CALIFORNIA**

14 In the Matter of the Accusation Against:

Case No. 800-2021-081546

15 **Richard Mark Goddard, M.D.**
225 N. Country Ln., Unit 78
St. George, UT 84770-8464

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. G 67660,**

18 Respondent.

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21 **PARTIES**

22 1. Reji Varghese ("Complainant") brings this Accusation solely in his official capacity
23 as the Interim Executive Director of the Medical Board of California, Department of Consumer
24 Affairs ("Board").

25 2. On or about December 11, 1989, the Medical Board issued Physician's and Surgeon's
26 Certificate No. G 67660 to Richard Mark Goddard, M.D. ("Respondent"). That certificate was in
27 full force and effect at all times relevant to the charges brought herein and will expire on
28 September 30, 2023, unless renewed.

1 **JURISDICTION**

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

5 4. Section 2220 of the Code states, in pertinent part:

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

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

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

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

19 **STATUTORY PROVISIONS**

20 5. Section 2234 of the Code, states, in pertinent part:

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

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

25 (b) Gross negligence.

26 (c) Repeated negligent acts. To be repeated, there must be two or more
27 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.

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

1 appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

2 (2) When the standard of care requires a change in the diagnosis, act, or
3 omission that constitutes the negligent act described in paragraph (1), including, but
4 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.

5 ...

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

7
8 The failure of a physician and surgeon to maintain adequate and accurate records
relating to the provision of services to their patients constitutes unprofessional conduct.

9
10 **COST RECOVERY**

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

12 (a) Except as otherwise provided by law, in any order issued in resolution of a
disciplinary proceeding before any board within the department or before the
13 Osteopathic Medical Board, upon request of the entity bringing the proceeding, the
administrative law judge may direct a licensee found to have committed a violation or
14 violations of the licensing act to pay a sum not to exceed the reasonable costs of the
investigation and enforcement of the case.

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

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

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

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

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

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

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

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

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

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

11 FACTUAL ALLEGATIONS

12 8. At all relevant times, Respondent was a physician and surgeon with a board
13 specialization in obstetrics and gynecological ("OB-GYN") care from the American College of
14 Obstetricians and Gynecologists. Prior to October 2019, Respondent owned and operated a
15 private obstetrics and gynecological practice that served the Sierra Nevada Memorial Hospital
16 community located in Grass Valley, California. Respondent relocated to the State of Utah
17 following the closure of his practice in October 2019. At all relevant times to the events alleged
18 in this Accusation, Respondent was solely providing locum tenens coverage for Sierra Nevada
19 Memorial Hospital as an OB-GYN.

20 9. On or about September 7, 2021, the Board received a complaint that Respondent was
21 meeting people in the parking lot of Sierra Nevada Memorial Hospital and providing COVID-19
22 vaccine exemptions. COVID-19 (coronavirus disease) is an infectious disease caused by the
23 SARS-CoV-2 virus that emerged in December 2019. While most people experience mild to
24 moderate symptoms, COVID-19 has been linked to 1,128,404 deaths as of April 19, 2023,
25 according to the Centers for Disease Control. On or about December 11, 2020, vaccines were
26 made available to healthcare workers, and later the public, to stem the spread of the virus. The
27 complainant alleged that Respondent may have been falsifying medical records and was
28 providing exemptions to hospital employees who did not wish to be vaccinated despite public

1 health mandates to require on-going vaccination. The Board opened an investigation into
2 Respondent.

3 Patient 1¹

4 10. On or about August 16, 2021, Respondent provided a written COVID-19 vaccine
5 exemption letter to Patient 1, an approximately 24-year-old female. At the time, Respondent had
6 no clinical office in the area, so he would either sneak the patient into the hospital or perform the
7 examination on the back tailgate of his truck in the hospital parking lot prior to granting the
8 exemption. The exemption letter stated that Patient 1, “has several health concerns that put her at
9 extra risk from vaccination for SARS-CoV-2. Her age, gender, brain tumor with seizure disorder,
10 ovarian dysfunction, and prior anaphylaxis should disqualify her from the shot.” Respondent had
11 last seen Patient 1 on a regular basis as her treating physician in August 2018. Respondent
12 documented a single page typed note on August 16, 2021, that was unsigned and not on letter
13 head, that noted a prior history as follows: “Relevant Clinical History: Long history with
14 her...Brain tumor + seizure disorder, on anti-epileptics for many years...Ovarian dysfunction-
15 PCOS vs. prog deficiency...Anaphylaxis, unsure of medication...” Respondent failed to
16 incorporate the August 16, 2021, progress note into Patient 1’s medical records that were kept by
17 any other physicians.

18 11. A review of Patient 1’s medical records from August 2015 to August 2018 make no
19 mention of a brain tumor, seizure disorder, or anaphylactic reaction to medication. Patient 1’s
20 medical records noted a morphine allergy, but no documentation of the type of reaction caused by
21 the allergy. Respondent failed to document that he performed an informed consent discussion
22 with Patient 1 regarding the risks and benefits of COVID-19 vaccination. Respondent failed to
23 document any further steps taken to determine the cause of Patient 1’s anaphylactic reactions to
24 medications, including obtaining additional medical records or referring her to an allergist-
25 immunologist for further evaluation and testing. Respondent documented that Patient 1’s age and
26 gender were risk factors warranting vaccine exemption when those demographics are not

27
28 ¹ All patient identifying information has been removed in order to protect patient privacy.
All patients will be fully identified in discovery.

1 recognized risk factors. Finally, Respondent failed to document any known medical conditions
2 for Patient 1 that were known contraindications to receiving the COVID-19 vaccine.

3 Patient 2

4 12. On or about August 21, 2021, Respondent provided a written COVID-19 vaccine
5 exemption letter to Patient 2, an approximately 43 year-old male. At the time, Respondent had no
6 clinical office in the area, so he would either sneak the patient into the hospital or perform the
7 examination on the back tailgate of his truck in the hospital parking lot prior to granting the
8 exemption. On or about September 7, 2022, a Board investigator spoke with Patient 2 who
9 confirmed he received a vaccine exemption letter from Respondent, but Patient 2 refused to
10 provide the vaccine exemption letter to the Board. Respondent never provided care to Patient 2
11 on a regular basis, as Patient 2 is a biological male patient and outside of the scope of
12 Respondent's training and specialization. As such, Respondent had no medical records
13 documenting any history of on-going care to Patient 2. According to Patient 2, Respondent
14 provided a vaccine exemption to Patient 2 when Patient 2 accompanied his wife to her OB-GYN
15 appointment with Respondent.

16 13. Respondent documented a one-page note, that was unsigned and without letterhead,
17 for the August 21, 2021, visit. Respondent documented that Patient 2 had a relevant clinical
18 history as follows: "I have known him as long as his wife. Autoimmune celiac disease.
19 Vaccination reactions, skin, local muscle, cardiac dysrhythmias (PSCT?), general malaise and
20 myalgias(sic)." Respondent noted that he would be writing an exemption letter for Patient 2 until
21 someone could confirm that the vaccine would be an acceptable risk for Patient 2. Respondent
22 noted that "injections, esp. vaccinations, have causes or been associated with atypical response,"
23 without providing more elaboration, especially as to Patient 2.

24 14. Respondent did not document any clinically valid reasons for the issuance of the
25 exemption. Respondent's documentation of general reactions to vaccines are common side
26 effects of any vaccine and not a basis for exemption. Respondent failed to refer Patient 2 to a
27 specialist in allergy and immunology despite documenting concerns related to cardiac
28 arrhythmias. Respondent failed to document an informed consent discussion with Patient 2

1 regarding the risks and benefits of vaccine, in particular the risk posed by not being vaccinated if
2 Patient 2 actually suffered from cardiac conditions.

3 Patient 3

4 15. On or about August 25, 2021, Respondent provided a written COVID-19 vaccine
5 exemption letter to Patient 3, an approximately 49-year-old female patient. At the time,
6 Respondent had no clinical office in the area, so he would either sneak the patient into the
7 hospital or perform the examination on the back tailgate of his truck in the hospital parking lot
8 prior to granting the exemption. Respondent provided on-going care to Patient 3 between May
9 2003 and September 27, 2018. The vaccine exemption stated that Patient 3 suffered from the
10 following: "Hashimoto's thyroiditis, frequent migraine headaches, Erosive Lichen Planus, and
11 has multiple sensitivities to medications and their stabilizers." The exemption further stated that
12 Patient 3's, "age and gender also increase her risk of complications." Finally, the exemption
13 stated, in addition, that Patient 3's, "frequent rashes, food sensitivities, and gastric problems make
14 the SARS-CoV-2 vaccine riskier for her than a low risk person."

15 16. Respondent did not author a medical record or progress note to support Patient 3's
16 COVID-19 exemption at or around the time that he provided the exemption to Patient 3.
17 Respondent failed to document an informed consent discussion with Patient 3 regarding the
18 benefits and risks of receiving the COVID-19 vaccine. Respondent failed to document any valid
19 reasons or concerns with Patient 3's health history that would warrant the issuance of a COVID-
20 19 vaccine exemption letter. Even if Respondent was concerned that Patient 3 might experience a
21 possible allergic reaction to the COVID-19 vaccine, Respondent failed to refer Patient 3 to an
22 allergist-immunologist.

23 Patient 4

24 17. On or about October 19, 2021, Respondent provided a written COVID-19 vaccine
25 exemption to Patient 4, an approximately 31-year old female patient. Patient 4 was pregnant at
26 the time she received her exemption. At the time, Respondent had no clinical office in the area,
27 so he would either sneak the patient into the hospital or perform the examination on the back
28 tailgate of his truck in the hospital parking lot prior to granting the exemption. The vaccine

1 exemption states as follows: Patient 4 “is pregnant and requests to avoid COVID booster and flu
2 shots for that reason. I agree because of her asthma and suffering from lymphadenopathy from
3 the COVID shot (Johnson and Johnson). The conditions point to an increased risk of serious
4 complications from this type of immunization and I recommend she be excused.”

5 18. On or about October 19, 2021, Respondent documented a one-page progress note that
6 was unsigned and not on Respondent’s letterhead. The Respondent did not incorporate the
7 progress note into Patient 4’s medical records that documented on-going treatment. The
8 Respondent documented that Patient 4 had been Respondent’s patient for many years, was
9 pregnant, and had asthma that was stable. The Respondent documented that Patient 4 had severe
10 lymphadenopathy after the COVID-19 vaccine. Respondent did not document any known
11 contraindications that would support an exemption from the COVID-19 vaccine. Respondent
12 incorrectly stated that asthma and pregnancy were contraindicated for Patient 4 getting the
13 COVID-19 vaccine. Respondent failed to refer Patient 4 to an allergist-immunologist to make
14 additional findings regarding lymphadenopathy, a known side effect to the COVID-19 vaccine.

15 19. Respondent failed to document an informed consent discussion with Patient 4
16 regarding the risks and benefits of receiving the COVID-19 vaccines. Specifically, Respondent
17 failed to document that he discussed with Patient 4 that she was at an increased risk of severe
18 disease without additional vaccination and that illness could have significant consequences
19 because she was pregnant. Respondent also failed to document that he discussed Patient 4’s
20 history of asthma, which could place her at a higher risk of severe disease if she did not receive
21 additional COVID-19 vaccines.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 20. Respondent's license is subject to disciplinary action under section 2234, subdivision
4 (b), of the Code, in that Respondent committed gross negligence during the care and treatment of
5 Patients 2 and 4. The circumstances are set forth in paragraphs 8 through 19, and those
6 paragraphs are incorporated by reference as if fully set forth herein.

7 21. Respondent committed gross negligence in the following distinct and separate ways:

8 a.) By providing a COVID-19 vaccine exemption to Patient 2, a male, who
9 had no valid contraindications to vaccination and without first referring Patient 2 for
10 additional specialist care for further testing; and,

11 b.) By providing a COVID-19 vaccine exemption to Patient 4, without
12 documenting an informed consent discussion that Patient 4 was at a higher risk of severe
13 disease without vaccination and this could impose severe consequences on her pregnancy.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

16 22. Respondent's license is subject to disciplinary action under section 2234, subdivision
17 (c), of the Code, in that Respondent committed repeated negligent acts during the care and
18 treatment of Patients 1, 2, 3, and 4. The circumstances are set forth in paragraphs 8 through 21,
19 and those paragraphs are incorporated by reference as if fully set forth herein.

20 23. Complainant realleges each of the distinct and separate gross departures as set forth in
21 paragraph 21, as distinct and simple departures from the standard of care.

22 24. Respondent committed repeated negligent acts in the following ways:

23 a.) By providing a COVID-19 vaccine exemption to Patient 1, who had no
24 validated contraindications to vaccination and without first referring Patient 1 for additional
25 specialist care for further testing;

26 b.) By providing a COVID-19 vaccine exemption to Patient 3, who had no
27 valid contraindications to vaccination and without first referring Patient 3 for additional
28 specialist care for further testing; and

1 . c.) By failing to document a progress note on August 25, 2021, including but
2 not limited to whether Respondent had an informed consent discussion with Patient 3 or
3 whether there was a valid basis for the COVID-19 vaccine exemption provided to Patient 3.

4 **THIRD CAUSE FOR DISCIPLINE**

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

6 25. Respondent's license is subject to disciplinary action under section 2266 of the Code
7 in that Respondent failed to maintain adequate and accurate medical records related to COVID-19
8 vaccine exemptions he provided to Patients 1, 2, 3, and 4.

9 26. The circumstances are set forth in paragraphs 8 through 24, and those paragraphs are
10 incorporated by reference as if fully set forth herein.

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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. G 67660, issued to Richard Mark Goddard, M.D.;

2. Revoking, suspending or denying approval of Richard Mark Goddard, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Richard Mark Goddard, M.D., to pay the Board the costs of the investigation and enforcement of this case in accordance with Business and Professions Code section 125.3, and if placed on probation, the costs of probation monitoring in accordance with Business and Professions Code section 2227, subdivision (a)(3); and,

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

DATED: MAY 04 2023

JENNA JONES FOX
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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