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

ROB BONTA
Attorney General of California
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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: **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 Respondent.	Case No. 800-2021-081546 **STIPULATED SURRENDER OF LICENSE 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. Reji Varghese ("Complainant") is the Interim 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 John S. Gatschet, Deputy Attorney General.

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

3. On or about December 11, 1989, the Board issued Physician's and Surgeon's Certificate No. G 67660 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-081546 and will expire on September 30, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-081546 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 May 4, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2021-081546 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2021-081546. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. 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 be represented by counsel, at his own expense; 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2021-081546, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 67019 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director, whether interim or permanent, on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or

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

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

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License 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.

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 67660, issued to Respondent Richard Mark Goddard, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-081546 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $23,170.00 prior to issuance of a new or reinstated license. The Board shall not grant a new or reinstated license until all cost recovery has been paid in full.

6. 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 agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2021-081546 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 licensure.

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.

DATED: June 12, 2023

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

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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: **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,** Respondent.	Case No. 800-2021-081546 **ACCUSATION**

PARTIES

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

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

JURISDICTION

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

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

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold 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:
>
> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a 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.
>
> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the 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.
>
> (c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

STATUTORY PROVISIONS

5. 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:
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> (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.

...

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

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

COST RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

FACTUAL ALLEGATIONS

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

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

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

Patient 1[1]

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

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

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

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

Patient 2

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

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

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

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

Patient 3

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

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

Patient 4

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

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

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

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

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

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

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

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

26. The circumstances are set forth in paragraphs 8 through 24, and those paragraphs are 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 for
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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