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

In the Matter of the Third Amended Accusation Against: WILLIAM J. ZINNANTI, M.D. Physician's and Surgeon's Certificate No. A 118089 Respondent.	Case No. 800-2018-040764

DECISION

The attached Decision 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. November 30, 2023.

IT IS SO ORDERED October 31, 2023.

MEDICAL BOARD OF CALIFORNIA

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

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:

WILLIAM J. ZINNANTI, M.D.,

Physician's and Surgeon's Certificate No. A 118089

Respondent.

Agency Case No. 800-2018-040764

OAH No. 2021110155

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on multiple dates between August 28, 2023, and September 11, 2023, by videoconference.

Deputy Attorneys General Thomas Ostly and Kendra Rivas represented complainant Reji Varghese, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Attorneys Nicholas Jurkowitz and Jeffrey J. Segal represented respondent William J. Zinnanti, M.D., Ph.D., who was present throughout the hearing.

The matter was submitted for decision on September 11, 2023.

FACTUAL FINDINGS

1. Since August 17, 2011, respondent William J. Zinnanti, M.D., Ph.D., has held Physician's and Surgeon's Certificate No. A 118089. As of October 22, 2021, this certificate was active and was scheduled to expire on April 30, 2023.

2. Acting in his official capacity, the former Executive Director of the Medical Board of California filed an accusation against respondent on January 14, 2021. Respondent requested a hearing. Acting in his official capacity, the Board's former Executive Director filed a first amended accusation against respondent on June 11, 2021; a second amended accusation on July 16, 2021; and a third amended accusation on January 4, 2023. Complainant Reji Varghese then became the Board's Interim Executive Director, and later its Executive Director.

3. The third amended accusation alleges a wide range of unprofessional conduct as cause for discipline against respondent. Complainant alleges that respondent departed from the standard of care in treating seven pediatric and two adult patients; that he has misrepresented his qualifications to the public; that he has permitted unlicensed persons to perform medical procedures that California law requires medical licensure to perform; and that he has prescribed controlled substances inappropriately for himself and his patients.

4. At the conclusion of the hearing, complainant moved to amend the third amended accusation by withdrawing the Thirteenth Cause for Discipline, on the ground that no evidence in the hearing record supported those allegations. Respondent did not oppose this motion, and it was granted.

Education and Professional Experience

5. Between 1991 and 1995, respondent patented several surgical devices. He received an undergraduate degree in 2001, a Ph.D. in 2006, and an M.D. in 2009.

6. Respondent's Ph.D. research related to congenital metabolic defects that cause childhood neurological damage. He completed a one-year pediatric internship in New York in 2010, and then enrolled in a four-year residency program in child neurology at Stanford University. The residency program's design was that residents would focus during the first two clinical years on adult neurology, during the third clinical year on pediatric neurology, and during the fourth year on research.

7. Respondent participated in only the first two clinical years of his Stanford University residency, for reasons summarized in greater detail below in Findings 11 through 13. At the end of the second year, the residency program's director described respondent in a closure letter as having "exhibited satisfactory to good performance during residency," and having completed the two clinical years "in good standing." Respondent also received a certificate stating that he had served between July 1, 2010, and June 30, 2012, as a "Fellow in Child Neurology."

8. Respondent is not eligible to become board-certified in neurology, because he has not completed a full neurology residency.

9. Respondent is in private practice in Santa Cruz. His practice emphasizes neurological concerns for both pediatric and adult patients.

10. In September 2020, respondent took a thirty-hour introductory course through the Undersea and Hyperbaric Medical Society, covering key aspects of oxygen therapy in a hard chamber pressurized to greater than 1.4 atmospheres with near-pure

oxygen. He has not completed proctoring, residency, or a fellowship in hyperbaric medicine.

Disciplinary History

11. While respondent pursued his M.D. and Ph.D., he also operated a medical device business. The business involved manufacturing medical devices in China, importing them in bulk to the United States, and packaging and sterilizing them before shipping them to the domestic distributor. Between January 1, 2005, and July 12, 2007, respondent shipped devices to the distributor that he had not packaged or sterilized properly. He represented falsely to the distributor, however, that he had packaged and sterilized the devices in accordance with relevant statutes and regulations.

12. In May 2012, respondent agreed after negotiations to plead guilty to a felony violation of United States Code, title 21, sections 331, subdivision (a), 351, subdivision (h), and 333, subdivision (a)(2) (introducing adulterated medical devices into interstate commerce). On May 14, 2012, the United States Attorney for the Middle District of Pennsylvania filed an information charging respondent with this crime. The court accepted respondent's plea on June 4, 2012; convicted him on January 28, 2013; and sentenced him to four months in prison (to begin June 3, 2013) followed by one year of supervised release.

13. In February 2012, respondent had received a letter confirming that he would continue to his third clinical residency year at Stanford University. Because of the matters summarized in Findings 11 and 12, however, the residency program's directors rescinded this offer to continue training respondent.

14. Respondent reported to the Board on June 5, 2012, that he had entered into the plea agreement described in Finding 12. The Board's former Executive Director filed an accusation against respondent on April 19, 2013, alleging that the conviction described in Finding 12 and the dishonest conduct it reflected (described in Finding 11) were cause to suspend or revoke respondent's physician's and surgeon's certificate. Respondent resolved this disciplinary matter by agreeing to entry of an order placing him on seven years' probation with the Board, and the Board entered this order effective January 10, 2014.

15. The Board's January 2014 probation order required respondent to demonstrate clinical competence by one of two methods: (1) by completing the Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego, followed by a professional enhancement program involving "quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education"; or (2) by completing a Board-approved medical residency program.

16. Respondent chose the first method. He enrolled in the PACE program in early 2014, representing that he intended to continue practicing as a neurologist. PACE program staff members reported to the Board that respondent demonstrated "good to excellent performance . . . consistent with safe practice and competency." A Board staff member notified respondent by letter dated May 7, 2014, that he could resume medical practice, and reminded him to enroll in either a residency or the professional enhancement program by July 6, 2014.

17. Respondent enrolled in the professional enhancement program. The same neurologist who had evaluated respondent's competence in the PACE program continued to serve as respondent's professional enhancement program mentor. This

neurologist visited respondent's medical office several times, and conducted chart reviews to evaluate respondent's patient care. Although the Board's January 2014 probation order stated that the Board might require respondent to continue in the professional enhancement program during his entire seven-year probation term, a Board staff member notified respondent by letter dated August 5, 2015, that further participation would not be necessary.

18. To satisfy the Board's January 2014 probation order, respondent also completed a course in professional ethics, and performed more than 80 hours of free non-medical community service.

19. The Board's January 2014 probation order required respondent to submit quarterly reports about his activities to the Board within 10 days after the end of each calendar quarter. On August 5, 2016, a Board staff member issued Citation No. 8002016024657 to respondent for failure to submit a timely quarterly report. The citation assessed a $350 fine, which respondent paid. The evidence reflects no other probation violations by respondent.

20. Respondent petitioned in July 2018 for early termination of his probation. When he filed this petition, Board staff members already had received and begun investigating complaints regarding Patients 1, 2, and 5; by the time a hearing occurred on the petition in January 2020, Board staff members also had received and begun investigating complaints regarding Patients 4, 6, 8, and 9. No evidence at that hearing addressed any of these complaints. The Board granted respondent's petition and terminated his probation effective April 17, 2020.

Pediatric Patient Care Allegations

21. Complainant alleges that respondent treated seven pediatric patients in an unprofessional manner during 2017 and 2018.

22. As to three of the children (Patients 1, 4, and 6), complaints to the Board about respondent's care arrived well after treatment had ended, and were from a Medi-Cal managed care provider rather than from the children's families. As to two other children (Patients 2 and 5), complaints came to the Board from the children's parents, at about the time the parents elected to end their children's treatment with respondent. As to Patients 3 and 7, the Board received no complaints; these children are siblings to Patients 4 and 6, respectively.

23. With respect to these pediatric patients, two expert witnesses testified regarding their opinions of respondent's medical care, based on their review of medical records and other documents. Respondent also testified to describe the patients and his medical decisions.

a. Dean Sarco, M.D., is a pediatric neurologist in a large multi-disciplinary medical group, whose practice emphasizes diagnosing and treating epilepsy. He completed a residency in child neurology in 2004 and a follow-up fellowship in epilepsy and clinical neurophysiology in 2005. Dr. Sarco's testimony demonstrated excellent clinical knowledge in his area of practice emphasis, but he acknowledged that he usually relies on other physicians in his medical group to evaluate and treat children whose chief challenges are behavioral. On several issues, Dr. Sarco's opinions also reflected poor attention to critical factual details in the patient records he had reviewed.

b. Richard Frye, M.D., Ph.D., is a neurologist who recently has entered private practice after many years practicing in academic medical centers. His practice emphasizes diagnosing and treating neurological disorders that have both physical and psychological manifestations, such as autism spectrum disorder and certain metabolic disorders. Dr. Frye completed a residency in child neurology in 2003, and a follow-up fellowship in behavioral neurology, learning disabilities, and psychology in 2005. Dr. Frye's testimony was overly deferential to respondent's judgment on many issues, but he demonstrated greater familiarity than did Dr. Sarco with the patients' full medical records and histories.

ISSUES COMMON TO MULTIPLE PEDIATRIC PATIENTS

24. Respondent is not a primary care physician. His records regarding each pediatric patient state the name of the physician who referred the patient to him. Respondent cared only briefly for Patients 3, 4, and 5, but his records regarding Patients 1, 2, 6, and 7 reflect ongoing consultation and cooperation with other physicians, mental health care providers, social service providers, and educators about these children. Dr. Sarco opined repeatedly that respondent had departed from the standard of care by noting and accepting diagnoses that other providers previously had made and by failing to follow up on complaints or diagnoses that other providers already either had addressed or were addressing. These opinions were not persuasive (as described below in greater detail in Findings 43, 61, 72, 78, 106, 112, 120, and 124), because they evaluated respondent's care as if he were the first and only physician to treat the patients rather than a specialist member of these patients' care teams.

25. Dr. Sarco evaluated respondent's prescriptions of lamotrigine and oxcarbazepine in light of his familiarity with these drugs as standard treatments for some forms of pediatric epilepsy. He believes that prescribing either drug in a daily

dose lower than is usual for seizure control, for a patient who does not definitely have epilepsy, is always a departure from the standard of care. Dr. Frye and respondent testified more persuasively, however, that both lamotrigine and oxcarbazepine have mood-stabilizing effects in children as well as in adults, and that many physicians prescribe one of these drugs, in a daily dose lower than is usual for seizure control, for patients who may benefit from this mood effect even though they do not meet diagnostic criteria for epilepsy. Such use of either drug may be a departure from the standard of care for a particular patient, but is not a departure in every case.

26. Respondent has equipment in his office to give patients a treatment he describes as "mild hyperbaric oxygen" therapy. The equipment consists of a soft-sided chamber, somewhat akin to a small tent, that closes with a zipper and that can maintain internal pressure up to but not greater than 1.4 atmospheres. A person receiving the therapy spends about an hour in the chamber, breathing gas that is about 95 percent oxygen through a mask. Electronic media devices are safe to use within the chamber during the treatment, and the chamber has both a window and a mechanism for the person inside to summon help. Respondent testified credibly that the chamber in his office is one that the manufacturer (Summit to Sea) sells not only for use in medical offices but also for home use.

27. Respondent gives patients (or their parents) who receive mild hyperbaric oxygen treatments a document that describes this therapy as "only FDA approved for acute mountain sickness. Use of mild hyperbaric oxygen for any other condition is considered off-label and alternative or compl[e]mentary medical care." He testified credibly that many patients report that oxygen therapy gives them relief from headaches, confusion, or fatigue, and that he recommends it to some patients as an adjunct to other treatments that he also provides or prescribes. Respondent also

testified credibly that some private insurance carriers will cover this treatment, but that Medi-Cal and Medicare will not.

28. Dr. Sarco criticized respondent's use of hyperbaric oxygen therapy for several patients, but much of his criticism rests on his mistaken belief that the therapy occurred in a hard chamber that delivers more oxygen at higher pressure, and thus carries significantly greater risk, than the soft chamber that respondent in fact uses.[1] In addition, although Dr. Sarco stated credibly and persuasively that no large-scale clinical studies have shown any form of oxygen therapy to be a clearly effective treatment for any of the problems that brought Patients 1 through 7 to respondent,[2] this testimony does not establish that respondent departed from the standard of care by offering this therapy to any of these patients along with the other, more conventional therapies he also offered them. With respect to respondent's provision of oxygen therapy to Patients 1 through 7, Dr. Sarco's opinion that this therapy was an extreme departure from the standard of care is uniformly unpersuasive.

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[1] This confusion arose in part because several patients' parents described the treatment simply, but mistakenly, as "hyperbaric oxygen," a term that usually connotes a hard chamber pressurized to greater than 1.4 atmospheres with near-pure oxygen.

[2] Dr. Sarco stated in his written report regarding one patient that "quality evidence" exists "to refute" the idea that hyperbaric oxygen therapy is effective for "post-concussion symptoms." The article he referenced to support this statement concludes, however, that although little high-quality clinical evidence exists about this treatment, "anecdotal evidence supporting the use of [hyperbaric oxygen therapy] with this population in particular is compelling and warrants further study."

29. For each of Patients 1 through 7, respondent's medical records repeat the majority of the patient's presenting medical history in every visit record. The records also include, for every visit, a statement about why that visit occurred as well as descriptions of respondent's observations, examination findings, and key advice to the parent who accompanied the patient. Despite stating his belief that physicians' documentation should be thorough, "describing services provided and their justification, the assessment and plan, [and] erring on the side of being more complete," Dr. Sarco opined for several patients that respondent's poor records constituted extreme departures from the standard of care. His criticism of the adequacy and accuracy of respondent's medical records for Patients 1 through 7 is uniformly unpersuasive.

30. Dr. Sarco opined for some patients that respondent had committed extreme departures from the standard of care by listing inaccurate or inappropriate "billing codes" in these patients' records. Some of these codes correspond to diagnoses, whereas others describe medical procedures. No evidence establishes why respondent included any codes in his patients' records, why he chose particular codes for particular patients and visits, or how he or his administrative staff members may have translated the codes into charges that respondent asked his patients or their insurance providers to pay. Moreover, Dr. Sarco acknowledged that his medical expertise is clinical, not administrative. His criticism of respondent's use of "billing codes" is uniformly unpersuasive.

PATIENT 1

31. Patient 1 was born in September 2008. In May 2017, she began treatment at Stanford Lucile Packard Children's Hospital (LPCH) after her mother reported extreme behavioral changes following an acute infectious illness. Physicians referred

Patient 1 to a specialty clinic within LPCH that treats children who may have Pediatric Acute-onset Neuropsychiatric Syndrome (PANS).

32. Medical records in evidence regarding Patient 1 from care she received at LPCH after respondent had stopped treating her show that Patient 1's physicians eventually came to believe that Patient 1's mother suffered from severe mental illness. They believed that Patient 1's mother was an unreliable historian regarding Patient 1's medical condition, and was causing harm to Patient 1. While respondent treated Patient 1, however, he acted on her mother's reports about Patient 1's behavior and health outside respondent's office as if those reports generally were true. Complainant does not allege, and no evidence suggests, that respondent acted unreasonably or unprofessionally by doing so.

33. Patient 1 saw Theresa Willett, M.D., Ph.D., in the LPCH PANS clinic on May 5, 2017. Dr. Willett documented a plan that included extensive laboratory testing to "assess for an underlying [central nervous system] inflammatory/autoimmune disease" as well as an electroencephalogram (EEG) "to evaluate for seizure activity." Dr. Willett also contemplated referring Patient 1 later for a sleep study "if appropriate."

34. Patient 1 underwent an EEG at LPCH on May 25, 2017. The interpreting neurologist (Aaron Lynn Cardon, M.D.) wrote in a report that the EEG showed "intermittent right posterior temporal 3–4 Hz slow activity, most prominently seen in sleep." He characterized the EEG as "abnormal" for this reason, describing this pattern as "a non-specific indicator of a structural or functional abnormality." Dr. Sarco, Dr. Frye, and respondent concur with this interpretation.

35. Respondent met Patient 1 and her mother for the first time on May 30, 2017. According to a note Patient 1's mother later sent to Dr. Willett, Patient 1's

mother brought Patient 1 to see respondent for the neurology-related aspects of Dr. Willett's overall diagnosis and treatment plan because his Santa Cruz office was more geographically convenient than LPCH for the family.

36. Patient 1's mother gave respondent a detailed history about Patient 1's behavioral problems, which respondent paraphrased in his medical note as "anxiety," obsessive and repetitive behavior, emotional lability, "staring spells," and "errors in her speech." She told respondent that Patient 1 usually slept for between 15 and 18 hours each day, and used a continuous positive airway pressure device at night because of previously diagnosed sleep apnea. Respondent observed, corroborating Patient 1's mother's report, that Patient 1 was unusually sleepy: "slept during entire discussion with mother, waking only for exam." He also examined Patient 1, and received and reviewed the report from Patient 1's May 25, 2017, EEG.

37. Respondent considered Patient 1's mother's description of Patient 1 as well as the abnormal EEG described above in Finding 34. He recommended to Patient 1's mother that Patient 1 start taking lamotrigine. His medical record explains that he made this recommendation on the hypothesis that Patient 1 might be experiencing "subclinical seizures at night affecting REM sleep."

38. Respondent also noted in Patient 1's medical record that he intended to confer closely with Dr. Willett about every step in Patient 1's care: "I explained to mother that we will work closely with PANS team for guidance in further work up and treatment. We discussed close follow up and repeat EEG after starting medication if PANS team agrees." He testified credibly that he acted in accordance with this note, conferring regularly with Dr. Willett about Patient 1.

39. Patient 1 began taking lamotrigine soon after respondent prescribed it. Her mother stopped giving it to her after a few days, however, telling respondent that Patient 1 had developed a rash. Any such rash did not persist or cause lasting harm to Patient 1.

40. Dr. Sarco, Dr. Frye, and respondent all understand that lamotrigine carries a special risk of causing a dangerous, potentially life-threatening rash in some patients, and that when patients begin using it they should start with a small dose and increase gradually to an appropriate, therapeutically effective dose.

a. Dr. Sarco testified that he believes respondent committed extreme departures from the standard of care not only by prescribing lamotrigine at all to Patient 1 but also by prescribing an initial dose that was too high and a dose increase schedule that was too fast.

b. Dr. Frye testified, in contrast, that lamotrigine was not an unreasonable choice or a departure from the standard of care for this patient, in light of the abnormal EEG described in Finding 34 and the behavioral problems that had caused Patient 1's mother to pursue treatment. This opinion is more persuasive than Dr. Sarco's opinion that lamotrigine was simply inappropriate for Patient 1.

c. Dr. Frye agrees with Dr. Sarco that respondent prescribed more initial lamotrigine, and a faster rate of increase, than is usual. He believes, however, that respondent did not depart from the standard of care by doing so, because lamotrigine "can be titrated quicker as long as the patient is watched closely and the family is well informed to watch for the rash." In light of this opinion, along with the matters summarized in Findings 38 and 39, Dr. Sarco's opinion that respondent committed an

extreme departure from the standard of care with respect to the lamotrigine increase schedule he prescribed for Patient 1 is not clearly and convincingly persuasive.

41. On June 6, 2017, respondent performed a lumbar puncture on Patient 1, and sent a sample of her cerebrospinal fluid (CSF) to a laboratory to test it for numerous proteins that might indicate differing forms of auto-immune encephalitis. Dr. Sarco believes that no medical indication existed for this painful procedure, and that respondent committed an extreme departure from the standard of care by performing it. This opinion is not persuasive. Respondent performed this procedure because LPCH's Dr. Willett[3] (and he) believed that CSF testing would be valuable in differential diagnosis for Patient 1, and because Patient 1 and her mother could travel more easily to respondent's Santa Cruz office than to LPCH for the lumbar puncture.

42. Patient 1 had a brain MRI at LPCH on June 20, 2017. It did not show any abnormality.

43. Patient 1 and her mother returned to respondent on June 22, 2017. He informed them that the CSF testing had not indicated any form of auto-immune encephalitis. Dr. Sarco stated his opinion that respondent had demonstrated his "lack

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[3] Dr. Sarco's belief that LPCH records include "no documentation that the Stanford PANS clinic recommended a lumbar puncture" is simply wrong. According to those records, Dr. Willett recommended CSF testing at her first consultation with Patient 1 and her mother. Respondent's medical records regarding Patient 1 also state specifically that respondent conferred with Dr. Willett about this plan.

of knowledge" by diagnosing auto-immune encephalitis in Patient 1,[4] but this opinion is not persuasive because respondent made no such diagnosis.

44. Respondent repeated an EEG for Patient 1 on June 24, 2017, because her mother had reported her to be "improving" (including sleeping considerably less) even without lamotrigine. This EEG showed focal slowing over Patient 1's left temporal region, in contrast to the May 25 EEG that had shown focal slowing on the right. Respondent also interpreted this EEG as showing no "electrographic seizures" and no "clinical seizure activity."

45. Dr. Sarco describes respondent as having interpreted the May 25 and June 24 EEG studies to show epilepsy, and believes that respondent committed an extreme departure from the standard of care by "fail[ing] to interpret EEG results properly." This opinion is not persuasive; respondent did not interpret either EEG as showing epilepsy. Rather, respondent, like Dr. Sarco and Dr. Frye, interpreted both EEGs as showing abnormal focal brain activity.

46. Respondent recommended to Patient 1's mother on July 13, 2017, that Patient 1 begin taking oxcarbazepine, for similar reasons to the reasons he previously had recommended lamotrigine. He suggested that Patient 1 should take this

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[4] Dr. Sarco also opined that respondent had departed from the standard of care by failing to refer Patient 1 to the Stanford PANS clinic, and by failing to consider treating her using appropriate protocols for an auto-immune encephalitis. In light of the fact that Patient 1 already was a patient in the PANS clinic, where she ultimately received several of the therapies Dr. Sarco references, this opinion is not persuasive.

medication for a few months, and that he then would evaluate its effectiveness by considering not only Patient 1's mood and behavior but also a repeat EEG.

47. As for lamotrigine, Dr. Sarco's opinion that prescribing oxcarbazepine for Patient 1 was an extreme departure from the standard of care is less persuasive than Dr. Frye's opinion that use of this medication was within the standard of care. Moreover, given respondent's reasons for believing that oxcarbazepine might benefit Patient 1, Dr. Sarco's opinion that respondent departed from the standard of care by planning to re-evaluate the medication's effectiveness after only a few months also is less persuasive than Dr. Frye's opinion that this course of action was within the standard of care.

48. On several occasions during summer 2017, Patient 1's mother brought Patient 1 to respondent's office for oxygen therapy,[5] which Patient 1's mother believed (according to her correspondence with Dr. Willett) to improve Patient 1's condition. At most of these visits, Patient 1 or her mother reported that Patient 1 arrived with a headache, which resolved after the oxygen therapy. Dr. Sarco opined that respondent had committed extreme departures from the standard of care both by describing these headaches in his records as "cluster" headaches and by failing to conduct a full and appropriate evaluation to diagnose and possibly prevent them. In light of the intensive diagnostic procedures and medical treatment Patient 1 already was receiving during that summer, however (summarized in Findings 38 and 41 through 44), Dr. Sarco's opinion that respondent should have done something for Patient 1's reported

[5] Respondent testified credibly that Patient 1 used the oxygen mask described in Finding 26, but objected to sitting inside the enclosed chamber.

headaches beyond treating them symptomatically and incorporating them into his ongoing consultation with Dr. Willett is not persuasive.

49. Respondent performed another EEG for Patient 1 on September 9, 2017, in part because Patient 1's mother had reported an event at home that resembled an epileptic seizure. The EEG showed "generalized and focal left temporal and central slowing," and respondent maintained Patient 1 on oxcarbazepine.

50. Throughout summer and fall 2017, both respondent's and Dr. Willett's notes reference Patient 1's "hypersomnia," although at times respondent's notes suggest that Patient 1's sleepiness had improved. None of the diagnostic measures Patient 1 underwent during that summer revealed any explanation for her unusual sleepiness, however.[6] In light of these procedures and treatment (and in light of Dr. Willett's plan to order a sleep study if no other measure explained or resolved Patient 1's sleepiness), Dr. Sarco's opinion that respondent committed any departure from the standard of care by not doing something more or different about Patient 1's reported hypersomnia is not persuasive.

51. In late September 2017, Dr. Willett's records reflect Patient 1's mother's dissatisfaction with respondent's care. Patient 1's mother described respondent to Dr. Willett as a "non believer"; respondent recalls that Patient 1's mother seemed "fixated" on testing Patient 1 for infections, which respondent deemed unnecessary. Dr. Willett agreed to refer Patient 1 to a LPCH neurologist for a second neurology opinion.

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[6] According to an October record from LPCH, Dr. Willett eventually learned that Patient 1 was sleepy during the day not despite also sleeping all night but because she was staying awake during the night to play a video game.

52. Patient 1 saw respondent for the last time on November 1, 2017. On December 13, 2017, a LPCH neurologist (Christopher Lee-Messer, M.D., Ph.D.) evaluated her. Dr. Lee-Messer recommended "a trial of coming off oxcarbazepine and reassess," and Patient 1 continued in his care at LPCH.

PATIENT 2

53. Patient 2 was born in 2009. Her mother took custody of her when she was an infant, because Patient 2's birth mother was in prison. Respondent understands Patient 2's birth mother to be the sister of Patient 2's adoptive mother, and understands from Patient 2's adoptive mother that Patient 2's birth mother used alcohol and methamphetamine while pregnant with Patient 2.

54. Pediatrician Garry Crummer, M.D., began seeing Patient 2 in August 2016. His notes state that Patient 2 "has been on many different medications for various things, including ADHD" [attention deficit hyperactivity disorder], and that Patient 2 most recently had undergone a "Neuropsych eval" at LPCH in March 2016. Nevertheless, Dr. Crummer's notes state his intention to refer Patient 2 back to LPCH for neurological and genetic evaluations. No records regarding Patient 2 from any prior or subsequent primary care pediatrician, or from LPCH, are in evidence.

55. Dr. Crummer's notes also mention Patient 2's mother's interest in several non-traditional treatments. She described numerous dietary restrictions for Patient 2; said that Patient 2 saw a "homeopath"; ascribed some of Patient 2's behavioral challenges to vaccination and expressed interest in taking Patient 2 to an anti-vaccination pediatrician in Monterey; and asked Dr. Crummer about "chelating therapy."

56. At Patient 2's next visit with Dr. Crummer, in October 2016, Patient 2's mother told Dr. Crummer that Patient 2 was seeing a local naturopathic doctor who had diagnosed "fungal overgrowth" and prescribed "supplements" for Patient 2. Dr. Crummer prescribed clonidine, a sedating medication, for Patient 2, to be taken at night to combat insomnia.

57. Dr. Crummer noted on January 4, 2017, that Patient 2 had undergone an EEG at LPCH, which he summarized as "abnormal EEG but without evidence of seizures." He understood that providers at LPCH believed an MRI of Patient 2's brain was "not warranted," but referred Patient 2 to respondent for evaluation, and "advice on need of MRI of brain to search for etiology for developmental delay."

58. Patient 2's mother returned to Dr. Crummer in February 2017 without having seen respondent. She told Dr. Crummer that she wanted to try giving Patient 2 "gabapentin again, as it helped with sleep and to prevent agitation." He prescribed this medication for Patient 2.

59. Respondent's first appointment with Patient 2 occurred on March 16, 2017. He testified that at this appointment and all others, Patient 2 was a child in "constant motion." Respondent noted his understanding that other providers already had diagnosed Patient 2 with fetal alcohol syndrome, and he observed facial features and behavior that he considered consistent with this diagnosis. Patient 2's mother told respondent that Patient 2's birth mother had a "seizure disorder." She also told respondent that Patient 2 was struggling in school: "attention and focus are an issue as well as some tantrums that affect school and interaction with other children."

60. Respondent documented having given Patient 2's mother this advice:

> Child clearly fits the criteria for fetal alcohol syndrome and intrauterine drug exposure which causes autistic like features and hyperactivity. We discussed that we have had good success with low-dose SSRI [serotonin-specific reuptake inhibitor] medication to help with agitation and Concerta, which helps with attention and focus. We discussed that fetal alcohol syndrome is a specific condition that doesn't require any further investigation into a cause. We discussed that the damage was done before the child was born and now the best effort should be made to help improve [the] child's condition.

61. Consistent with his advice to Patient 2's mother, respondent prescribed fluoxetine (an SSRI medication) and Concerta (extended-release methylphenidate, a medication often used to treat ADHD) to Patient 2. Dr. Sarco opined that respondent committed extreme departures from the standard of care by prescribing these medications to Patient 2, and by diagnosing her with ADHD and autism spectrum disorder without having conducted complete diagnostic evaluations. This opinion is not persuasive, because it disregards Patient 2's treatment history (as summarized in Finding 54) and misstates respondent's diagnosis (as summarized in Finding 60).

62. Because Dr. Crummer had referred Patient 2 to respondent for a neurological second opinion, respondent recommended to Patient 2's mother that Patient 2 undergo a second EEG. After some delay, Patient 2 had that EEG on June 3, 2017. Respondent's interpretive notes state that the "recording was dominated by 5-6 Hz generalized slow activity. No epileptiform discharges were noted during the

recording. No clinical seizure activity was noted." He summarized the EEG as "abnormal . . . due to excessive generalized slow activity."

63. Dr. Sarco faults respondent for having committed an extreme departure from the standard of care by performing the EEG described in Finding 62 "with no indication." This opinion is not persuasive, in light of Patient 2's mother's reasons for bringing Patient 2 to respondent and Patient 2's family history of seizure disorder (all summarized in Finding 59). Furthermore, Dr. Sarco offers no explanation for his belief that ordering an EEG without strong clinical reasons to suspect overt seizures is any departure from the standard of care, rather than simply a difference in practice. In addition, Dr. Sarco faults respondent for having proposed another EEG in August 2017, but his opinion that simply noting "Consider repeat EEG" in the medical record was an extreme departure from the standard of care is not persuasive.

64. Dr. Sarco also faults respondent's interpretation of Patient 2's June 2017 EEG. He acknowledges that the "slowing" respondent observed is "indicative of cerebral dysfunction," but believes that respondent committed an extreme departure from the standard of care by hypothesizing that this dysfunction might be "subclinical seizures." He also understands, solely in reliance on a "billing code" in respondent's records and despite the narrative explanation in respondent's notes, that respondent diagnosed Patient 2 incorrectly with generalized absence epilepsy. Respondent did not diagnose or suspect generalized absence epilepsy in Patient 2, and Dr. Frye's opinion that Patient 2's EEG might have reflected electrical activity that was abnormal enough to disrupt Patient 2's brain function yet not abnormal enough to produce an overt seizure is more persuasive than Dr. Sarco's opinion otherwise.

65. Respondent saw Patient 2 and her mother several times during summer 2017. His notes reflect growing frustration with Patient 2's mother, both because of

her failure to follow his medication recommendations and because of her interest in diagnostic measures and therapies that he believed unnecessary or potentially harmful. His notes also reflect increasing concern that Patient 2's mother was not giving Patient 2 an adequate quantity or quality of food. Respondent documented recommending to Patient 2's mother that she "focus on behavioral concerns and helping her child get services that she needs instead of looking for additional and alternative diagnoses."

66. In Dr. Sarco's opinion, respondent committed a simple, uninformed departure from the standard of care by failing to pursue "urgent further investigation" into the possible reasons for Patient 2's "microcephaly, dysmorphic features, and language delay." This opinion is unpersuasive for at least three reasons. First, Dr. Crummer, not respondent, was Patient 2's primary care pediatrician; respondent was a specialist to whom Dr. Crummer had referred Patient 2 as part of Dr. Crummer's coordination of Patient 2's overall care. Second, Dr. Crummer's records state (as summarized in Finding 54) that Patient 2 had undergone significant evaluation before Dr. Crummer referred Patient 2 to respondent. And third, Dr. Crummer's records also state that on August 8, 2017, he made a further referral for Patient 2 to a developmental pediatric clinic at LPCH precisely because of Patient 2's apparent fetal alcohol syndrome and her clear developmental delay.

67. At an office visit on August 12, 2017, Patient 2 presented with some shortness of breath, although with no unusual lung sounds on physical examination and with normal oxygen saturation. Respondent gave Patient 2 some oxygen in the mild hyperbaric chamber, and her shortness of breath resolved. Dr. Sarco opined that respondent had committed a simple departure from the standard of care by failing on this occasion to refer Patient 2 to Dr. Crummer or to an urgent care clinic. This opinion

is not persuasive, because all evidence regarding Patient 2 shows that her mother was attentive to Patient 2's health and fully capable of contacting Dr. Crummer if and when Patient 2 needed his services.

68. Respondent's records from an office visit with Patient 2 and her mother on February 21, 2018, show that Patient 2's mother had decided on her own to stop giving Patient 2 one of the medications respondent previously had prescribed. Respondent recommended to Patient 2's mother that Patient 2 begin taking oxcarbazepine instead. Dr. Sarco's opinion that prescribing oxcarbazepine for Patient 2 was an extreme departure from the standard of care is less persuasive than Dr. Frye's opinion that use of this medication was within the standard of care.

69. Respondent's records from February 21, 2018, show that he and Patient 2's mother disagreed about Patient 2's care: "Long difficult discussion with mother today about the expectations for the child and asking me and other practitioners to 'fix my child.'" He also noted that Patient 2's mother had described putting up a "baby gate" to keep Patient 2 out of her mother's bedroom. Finally, after Patient 2 and her mother left, respondent's staff members told him that Patient 2 had told them that her mother was "mean" to her.

70. Respondent made a report to the child protective services agency in Patient 2's county on March 14, 2018. He reported that he suspected Patient 2's mother of neglecting her, by giving her "unreasonable restrictive diets" and by failing to supervise her adequately. After learning about this report, Patient 2's mother complained to the Board on April 27, 2018, that respondent had spoken disrespectfully and unprofessionally to her. No non-hearsay evidence supported this characterization; and in light of all evidence, it is not credible.

PATIENT 3

71. Patient 3 was born in 2008. At his first visit to respondent, on September 21, 2018, Patient 3's mother told respondent that Patient 3 had autism spectrum disorder, for which he had received behavioral therapy for several years. She described Patient 3 as hyperactive, inattentive, and anxious, and as a poor sleeper. She did not report that Patient 3 ever had experienced "convulsive seizures," but stated that he had notable "leg twitches" during sleep.

72. Based again on respondent's use of "billing codes" rather than on respondent's detailed notes, Dr. Sarco believes that respondent committed an extreme departure from the standard of care by diagnosing Patient 3 with generalized anxiety disorder and epilepsy. Respondent made no such diagnoses; rather, he described anxiety as a symptom, and listed potential differential diagnoses of "autism spectrum disorder, anxiety, sub clinical epilepsy, neurometabolic disorder or other." Dr. Sarco's unsupported opinion is not persuasive.

73. Respondent recommended an EEG for Patient 3. Dr. Sarco believes that respondent committed an extreme departure from the standard of care by doing so, because Patient 3's presentation gave "no suspicion of seizures." To the contrary, Patient 3's mother brought him to respondent because of unusual restlessness during sleep; moreover, both respondent and Dr. Frye noted credibly and persuasively that children with autism spectrum disorder have a much greater incidence of epilepsy than children who do not have autism spectrum disorder. Dr. Sarco also offers no explanation for his belief that ordering an EEG without strong clinical reasons to suspect overt seizures is any departure from the standard of care, rather than simply a difference in practice. Dr. Sarco's opinion that an EEG for Patient 3 was an extreme departure from the standard of care is not persuasive.

74. Patient 3's EEG occurred on November 3, 2018. Respondent observed that while Patient 3 was asleep, he experienced "frequent prolonged episodes of automatisms of the right jaw" at the same time as "3 Hz slowing over the right temporal region." In testimony, respondent described the "automatisms" as a "chewing motion." He testified, and documented, that these observations suggested to him that Patient 3 might be experiencing focal seizures during sleep.

75. Respondent recommended on November 7, 2018, that Patient 3 begin taking oxcarbazepine. He testified that he made this recommendation because he believed that this medication might improve Patient 3's behavioral challenges, particularly anxiety, and his sleep. Dr. Sarco's opinion that prescribing oxcarbazepine for Patient 3 was an extreme departure from the standard of care is less persuasive than Dr. Frye's opinion that use of this medication was within the standard of care.

76. Patient 3's parents did not bring Patient 3 back to respondent; instead, they sought a second opinion about him from LPCH. Medical records from LPCH state that Patient 3's parents did begin giving Patient 3 oxcarbazepine. He reported to a neurologist at LPCH that he did not like "how it makes him feel," and his parent(s) reported no "appreciable change" in his sleep quality or waking behavior. For this reason, the neurologist (Emily Mathews Spelbrink, M.D., Ph.D.) suggested that Patient 3 stop taking oxcarbazepine and that LPCH conduct further evaluation.

PATIENT 4

77. Patient 4, Patient 3's sibling, was born in 2009. At her first visit to respondent, on October 1, 2018, Patient 4's mother told respondent that Patient 4 also had autism spectrum disorder, which for Patient 4 caused "focus and attention concerns and difficulty with transitions and not wanting to engage in new things."

Patient 4 spoke minimally to respondent during his examination, and failed to answer most of his direct questions to her.

78. Based again on respondent's use of "billing codes" rather than on respondent's detailed notes, Dr. Sarco believes that respondent committed an extreme departure from the standard of care by diagnosing Patient 4 with ADHD, generalized anxiety disorder, and obsessive-compulsive disorder (OCD). Respondent made no such diagnoses; rather, he described several characteristics of Patient 4's behavior, and listed potential differential diagnoses of "autism spectrum disorder, anxiety, OCD, absence epilepsy and or neurometabolic disorder." Dr. Sarco's unsupported opinion is not persuasive.

79. Respondent recommended an EEG for Patient 4. Dr. Sarco believes that respondent did so "without any indication," and thus committed an extreme departure from the standard of care. The increased epilepsy incidence among children with autism spectrum disorder referenced in Finding 73 is an indication, however. Furthermore, Dr. Sarco offers no explanation for his belief that ordering an EEG without strong clinical reasons to suspect overt seizures is any departure from the standard of care, rather than simply a difference in practice. Dr. Sarco's opinion that an EEG for Patient 4 was an extreme departure from the standard of care is not persuasive.

80. Patient 4's first EEG occurred on October 13, 2018. Respondent's report noted no "epileptiform discharges," but "high amplitude slowing" coupled with "confusion" during hyperventilation. He considered the EEG abnormal for this latter reason, although he described it later in his notes as "equivocal." Because Patient 4 did not sleep during this study, respondent recommended that Patient 4 undergo a second, longer EEG at a time when she could be observed during sleep. Patient 4's

second EEG occurred on November 20, 2018, and respondent's report described this study as "similar" to the first EEG.

81. Dr. Sarco disagrees that either EEG pattern was abnormal, and characterizes respondent's belief as an extreme departure from the standard of care. In light of respondent's own characterization that the EEG was "equivocal," this opinion is not persuasive.

82. Respondent recalls that he discussed the possibility with Patient 4's mother that oxcarbazepine would benefit Patient 4. His records do not reflect that he ever prescribed it for her, however. Instead, they show that Patient 4 never returned to respondent after her EEG on November 20, 2018.[7]

83. Dr. Sarco criticizes respondent for having erroneously diagnosed Patient 4 with epilepsy, but no evidence shows respondent to have made such a diagnosis. Likewise, Dr. Sarco criticizes respondent for having prescribed oxcarbazepine to Patient 4, but the record on which he bases this criticism states only that respondent discussed this possibility with Patient 4's mother, who then did not bring Patient 4 back for further care. Dr. Sarco's unsupported opinions are not persuasive.

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[7] Patient 4's parents also took Patient 4 to LPCH. Records from LPCH state that Patient 4 was taking oxcarbazepine in January 2019, but they do not explain who prescribed it, when, or why.

PATIENT 5

84. Patient 5 was born in 2004. Respondent was acquainted with Patient 5 and her mother before Patient 5 became respondent's patient, because Patient 5 attended school with respondent's child.

85. Patient 5's pediatrician referred Patient 5 to respondent after Patient 5 experienced an episode at home that resembled an epileptic seizure. Her mother brought Patient 5 to see respondent for the first time on February 19, 2018.

86. Respondent's records show that Patient 5's mother described Patient 5's recent seizure-like event. She also said that Patient 5 had experienced febrile seizures in infancy and early childhood, and that even as a teenager she needed to urinate multiple times during the night and sometimes wet the bed. Respondent performed physical and neurological examinations in which he observed nothing abnormal.

87. On February 23, 2018, Patient 5 returned to respondent for an EEG. He observed "frequent (17 episodes in 20 minutes) generalized 3 Hz spike and wave discharges," but no overt "clinical seizure activity."

88. Based on Patient 5's symptoms and EEG, respondent diagnosed generalized absence epilepsy, and Dr. Sarco testified that he agreed with this diagnosis. He nevertheless reported, and testified, that he believed respondent to have

committed simple departures from the standard of care by misinterpreting Patient 5's EEGs.[8] This opinion is not persuasive.

89. Respondent prescribed lamotrigine for Patient 5, beginning with 50 milligrams per day divided between morning and evening and increasing to 100 milligrams per day after two weeks. Dr. Sarco believes that respondent committed an extreme departure from the standard of care by prescribing an initial lamotrigine dose that was too high (50 milligrams per day rather than 25 milligrams per day) and a dose increase schedule that was too fast. As for Patient 1, Dr. Sarco's opinion is not clearly and convincingly persuasive in comparison with Dr. Frye's opinion that respondent's dosing advice for this medication for Patient 5 was within the standard of care.

90. Respondent saw Patient 5 and her mother again on March 16, 2018. He recorded that Patient 5's mother "again states that she has concerns over medication and distrust of pharmaceuticals," and that he responded by emphasizing that Patient 5 "needs treatment" but that "lamotrigine might not be the correct choice if she is too tired." He recommended repeating an EEG and "discussing further plan afterward."

91. Respondent's medical records for visits with Patient 5 and her mother on February 18 and March 16, 2018, state that they "[d]iscussed seizure safety and plan." The records also show that respondent filled out a "Seizure Healthcare Plan" form for Patient 5's school. Dr. Sarco opined that respondent had committed an extreme departure from the standard of care by failing either to discuss or to document

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[8] Dr. Sarco's report also complains that he requested "the EEG tracings" but did not receive them. The evidence shows that respondent provided electronic recordings from both Patient 5's in-office EEG studies to the Board investigator.

discussing seizure safety with Patient 5 and her mother, but this opinion is not consistent with the evidence.

92. Patient 5 had a follow-up EEG on March 19, 2018. This study showed no "epileptiform discharges." Respondent believed that this result indicated that lamotrigine was having the effect he intended, but that Patient 5 should increase her daily dose of lamotrigine for reliable seizure control.[9] Her mother disagreed, and respondent recommended that she consult another pediatric neurologist. He sent a letter about Patient 5 dated April 12, 2018, to the pediatrician who had referred her, for their use in seeking another opinion.

93. Patient 5's mother complained to the Board on April 18, 2018, that respondent's behavior toward her in February and March 2018 had been extremely disrespectful. No non-hearsay evidence corroborated this complaint. Respondent acknowledged in testimony that Patient 5's mother resisted his advice to increase Patient 5's lamotrigine dose, but stated credibly that he had avoided disrespectful language while explaining to Patient 5's mother why he believed that Patient 5 needed anti-seizure medication.

PATIENT 6

94. Patient 6 was born in 2003. When he saw respondent first on June 8, 2017, Patient 6 already was in care with a psychiatrist who had diagnosed ADHD and prescribed Concerta, Ritalin (short-acting methylphenidate), and guanfacine (a sedating medication that also is used for ADHD, but that Patient 6 currently was not

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[9] According to reference materials in evidence, a "usual maintenance dose" of lamotrigine as an anti-seizure medication is between 225 and 375 milligrams per day.

taking). Despite these medications, and despite having his mother serve as his one-on-one aide at school, Patient 6 was struggling both academically and behaviorally. He had failed two classes during the most recent academic year and been "out of school two weeks early due to violence and bullying with other students."

95. Respondent examined Patient 6, noting that Patient 6's head circumference was smaller than the second percentile for Patient 6's age and that he had mild "hypotonia" (floppy muscles). He also recorded that Patient 6's mother reported Patient 6 to have suffered a concussion playing football in February 2016, as well as at least two known head injuries as a small child. She said that Patient 6 had experienced febrile seizures.

96. Respondent made several recommendations to Patient 6's mother at Patient 6's first visit. He recommended an EEG, as a first step to assessing whether any undiagnosed but treatable neurological problem might explain Patient 6's anti-social behavior. He also recommended that Patient 6 resume using guanfacine, stop using Ritalin, and perhaps in the longer term stop using Concerta as well, on the theory that stimulant medication such as methylphenidate might be contributing to Patient 6's impulsivity and violence. Finally, he suggested mild hyperbaric oxygen treatment.

97. Patient 6 had an EEG on June 24, 2017. Respondent interpreted it as an "abnormal EEG in wakefulness due to 3-6 Hz slowing over the right frontotemporal region," but saw no "electrographic" or "clinical" seizures. Dr. Sarco concurs that this pattern is abnormal.

98. Patient 6 returned to respondent on July 6, 2017. He had begun taking fluoxetine, which respondent had not prescribed. According to Patient 6's mother, this medication was making Patient 6 "more hyper." Patient 6's psychiatrist also had

recommended olanzapine (an anti-psychotic medication) for Patient 6, but Patient 6's mother had been thus far unable to fill that prescription.

99. Respondent testified credibly that he contacted Patient 6's psychiatrist at about this time to ensure that they coordinated Patient 6's care. They agreed that respondent would prescribe mood- and behavior-altering medications for Patient 6, although respondent did not purport to assume full responsibility for all Patient 6's mental health care.[10] Respondent proposed to Patient 6's mother that Patient 6 abandon fluoxetine; try again to obtain insurance coverage for olanzapine; and in the meantime begin taking oxcarbazepine, primarily for its mood-stabilizing effect. He also recommended an MRI of Patient 6's brain as the next diagnostic step.

100. Patient 6 had the MRI on July 27, 2017. The radiologist who interpreted it saw no "gross abnormalities," but stated that visibility was poor because Patient 6's metal orthodontic braces interfered with imaging. Because of this interference, Patient 6 had a follow-up computerized tomography (CT) scan on July 31, 2017, which also appeared normal.

101. Dr. Sarco testified that he believes that an MRI was appropriate for Patient 6. Despite the fact that Patient 6's braces made the MRI only marginally informative, however, Dr. Sarco also testified that he considers respondent's order for a subsequent CT scan a simple departure from the standard of care. This opinion is not persuasive.

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[10] Patient 6 continued in regular care with one or more mental health providers throughout the fifteen-month period that respondent cared for him.

102. Patient 6 had another EEG on July 29, 2017, that respondent interpreted as showing "intermittent spikes over the temporal regions bilaterally" but no "electrographic" or "clinical" seizures. Dr. Sarco concurs as well that this observation is abnormal.

103. By the time of a follow-up visit on July 31, 2017, Patient 6 had begun taking olanzapine and oxcarbazepine and had stopped taking Concerta. Respondent recommended at this visit that Patient 6 also stop taking guanfacine. Records from the next few months show that the olanzapine and oxcarbazepine combination helped Patient 6 behave more appropriately at school and at home, but that his maladaptive behavior returned quickly during periods when he neglected or refused medication.

104. Patient 6 had further EEG studies on November 14, 2017, and January 24, 2018. Respondent characterized these studies in his notes as "follow up routine EEG to check medication efficiency." Both studies were essentially normal.

105. Dr. Sarco believes that no "clinical indication" existed for any of the EEG studies respondent ordered for Patient 6, and that ordering them was an extreme departure from the standard of care. Dr. Sarco offers no explanation for his belief that ordering an EEG without strong clinical reasons to suspect overt seizures is any departure from the standard of care, rather than simply a difference in practice. Moreover, Dr. Sarco disregards respondent's notes to the effect that Patient 6's mother had identified "staring spells," as well as the fact that no prior diagnostic efforts had produced an adequate explanation or intervention for Patient 6's troubling behavior. Dr. Sarco's opinion that EEGs for Patient 6 were extreme departures from the standard of care is not persuasive.

106. Respondent's notes from a visit on March 28, 2018, state that respondent's mother had been "seen by Genetics and Developmental Peds at" the University of California, San Francisco (UCSF). They also state respondent's understanding that Patient 6 would have further genetic testing at UCSF. No UCSF records about Patient 6 are in evidence. Nevertheless, Dr. Sarco opines that respondent departed from the standard of care by failing to seek "genetic evaluation" of Patient 6 in light of his microcephaly and behavioral challenges. This opinion is not persuasive.

107. On March 28, 2018, Patient 6's mother asked respondent to order "lab tests" for Patient 6. He did, and they showed among other things that Patient 6's Vitamin D level was low. Respondent's records do not reflect any discussion with Patient 6's parents about this result, which Dr. Sarco deems a simple departure from the standard of care. Respondent testified credibly, however, that he interacted frequently by telephone with Patient 6's mother, and that he summarized the laboratory testing results to her. The evidence does not establish a departure from the standard of care.

108. Respondent last saw Patient 6 on September 21, 2018. Over the summer, Patient 6 had been using cannabis heavily and had not been taking his prescription medications correctly. Respondent counseled Patient 6 about the importance of using prescription medications as prescribed, and of abstaining from cannabis.

109. Later in fall 2018, Patient 6's parents took him to LPCH for another neurological opinion. After evaluation, LPCH neurologist Gustavo Adolfo Charria-Ortiz, M.D., concluded that Patient 6 probably did not need anti-convulsant medication to prevent epileptic seizures, but noted that he would defer "such a decision to [Patient 6's] neurologist/psychologist as such an agent has been also inducing positive

mood changes." The evidence does not establish what further care Patient 6 received, or from whom.

110. Dr. Sarco testified that he understood respondent to have diagnosed generalized absence epilepsy in Patient 6, and opined that this diagnosis was an extreme departure from the standard of care. More generally, Dr. Sarco opined that respondent had misinterpreted all of Patient 6's EEGs in a manner constituting extreme departures from the standard of care and incompetence. Respondent's records do not state that he ever diagnosed Patient 6 with any form of epilepsy, however, and Dr. Sarco's report states that he concurs with respondent's interpretation of each of Patient 6's EEG studies. Dr. Sarco's opinions are not persuasive.

111. Dr. Sarco also testified that respondent committed an extreme departure from the standard of care by prescribing oxcarbazepine to Patient 6. He explained this opinion by stating both that respondent never diagnosed Patient 6 with any epilepsy and that oxcarbazepine is an inappropriate medication for absence epilepsy.[11] In light of the matters stated in Findings 25 and 109, however, Dr. Sarco's opinion that prescribing oxcarbazepine for Patient 6 was an extreme departure from the standard of care is less persuasive than Dr. Frye's opinion that use of this medication for Patient 6 was within the standard of care.

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[11] Respondent and Dr. Frye agree that oxcarbazepine is inappropriate for patients with generalized epilepsy. The only patient in whom respondent actually diagnosed this form of epilepsy, based both on her EEG and her clinical presentation, is Patient 5, for whom respondent did not prescribe oxcarbazepine.

112. According to Dr. Sarco, respondent committed an extreme departure from the standard of care by assuming sole responsibility for Patient 6's mental health care, by diagnosing various mental disorders (including oppositional defiant disorder, psychosis, and autism spectrum disorder) himself rather than referring Patient 6 to a psychiatrist, and by prescribing psychoactive medications. This opinion bears little relationship to the facts of Patient 6's care, as documented in respondent's records and as described by respondent in his interview with Board investigators and his testimony. It is not persuasive.

113. Dr. Sarco opined that respondent had spoken rudely and unprofessionally to Patient 6's mother, in a manner constituting a simple departure from the standard of care. No non-hearsay evidence supported this opinion, and it is neither credible nor persuasive.

PATIENT 7

114. Patient 7, Patient 6's half-sibling, was born in 2011. In 2016, his primary care pediatrician referred him to the LPCH Developmental Behavioral Pediatrics Clinic because of concern about his disruptive, impulsive behavior, his poor academic skills, and his difficulty in socializing.

115. An interdisciplinary team at the Developmental Behavioral Pediatrics Clinic diagnosed Patient 7 with ADHD. In May 2017, they prescribed Concerta for Patient 7.

116. Patient 7's mother consulted respondent with Patient 7 on September 13, 2017. Respondent's records state that she did not believe that Concerta was very effective for Patient 7, and that he also experienced staring spells and "sharp

headaches." She also said that he had experienced both febrile and afebrile seizures in the past.

117. Patient 7 underwent an EEG on October 21, 2017. Although Patient 7 showed no "clinical seizure activity," the electrical recording captured "a few spikes and epileptiform discharges lasting 1-3 seconds and centered over the left central and temporal regions." Respondent performed a much longer EEG of Patient 7 on November 18, 2017, with similar results. A third EEG on January 19, 2018, also was similar, showing "a few spikes and 2 generalized 3 Hz spike and wave epileptiform discharges." A fourth EEG on April 24, 2018, was normal.

118. As for Patient 7's brother, Patient 6, Dr. Sarco believes that no "clinical indication" existed for any of the EEG studies respondent ordered for Patient 7, and that ordering them was an extreme departure from the standard of care. Dr. Sarco offers no explanation for his belief that ordering an EEG without strong clinical reasons to suspect overt seizures is any departure from the standard of care, rather than simply a difference in practice. Moreover, Dr. Sarco disregards respondent's notes to the effect that Patient 7's mother had identified "staring spells" and afebrile seizures in Patient 7, and had continued to report such events even after Patient 7 had started taking medication with anti-epileptic effects. Dr. Sarco's opinion that EEGs for Patient 7 were extreme departures from the standard of care is not persuasive.

119. After Patient 7's first abnormal EEG, respondent prescribed oxcarbazepine to him. Patient 7 developed a severe rash within a few weeks of starting this medication, which resolved after he stopped taking it. Respondent then prescribed valproic acid, another medication that is used both as an anti-seizure drug and a mood stabilizer. At the maximum dose respondent prescribed, Patient 7 complained

that this medication gave him a stomachache; respondent reduced the dose somewhat to relieve this effect.

120. Patient 7 returned to the LPCH Developmental Behavioral Pediatrics Clinic in early January 2018. Providers there noted that respondent had prescribed different medications for Patient 7 from the medications they had prescribed. They wrote that they "agree with the plan for his neurologist to take over his ADHD treatment," but also that Patient 7's mother "is not satisfied with the current management of his inattention. We recommend that [Patient 7] be seen by one of our neurology colleagues for a second opinion on his seizures and management."

121. Later in January 2018, the LPCH records reflect a conversation between respondent and an LPCH physician. Respondent sent the physician an excerpt from the recording of Patient 7's January 19, 2018, EEG, showing one of the "spikes" he had observed, and noted his plan to increase Patient 7's daily valproic acid dose.

122. Patient 7 had a brain MRI on April 13, 2018, that showed no abnormality. He also had a sleep study in May 2018 in which he experienced "mild sleep disordered breathing without clinically significant obstructive sleep apnea."

123. Respondent last saw Patient 7 on September 21, 2018. Like Patient 6, Patient 7 had not been taking his prescribed medications consistently during the summer, and his mother reported that he was "not doing well." Later that same month, respondent conferred with a psychologist about Patient 7.

124. Dr. Charria-Ortiz at LPCH later took over Patient 7's care. After further abnormal EEGs and at least one overt seizure, Dr. Charria-Ortiz recommended switching from valproic acid to a different anti-epileptic medication that turned out, according to Patient 7's mother, to be more effective and better tolerated by Patient 7.

Dr. Charria-Ortiz noted an association between Patient 7's abnormal brain electrical activity and his "cognitive and behavioral issues," but some ambiguity about the precise nature of Patient 7's epilepsy: "despite EEG reports, his clinical picture is not clearly consistent with Benign Rolandic Epilepsy and more with a localization related (likely multifocal) epilepsy with secondary generalized motor seizures."

125. Dr. Sarco opines that respondent committed extreme departures from the standard of care by misinterpreting Patient 7's EEG results "as being supportive of absence epilepsy," and compounded this error by initially prescribing oxcarbazepine, which is inappropriate for generalized absence epilepsy. Although respondent's records do use the phrase "absence epilepsy" to describe Patient 7's working diagnosis, his narrative as well as his testimony and his prescribing do not show that he believed Patient 7 to have a generalized epilepsy when he prescribed oxcarbazepine. Rather, according to these records and to respondent's testimony, Patient 7's October 2017 and November 2017 EEG studies suggested to respondent that Patient 7 was experiencing focal electrical abnormalities that interfered with his attention and cognition. In light of all evidence about Patient 7 (summarized in Findings 114 through 124), Dr. Sarco's opinion that respondent's diagnostic reasoning and his initial choice to prescribe oxcarbazepine were extreme departures from the standard of care is not persuasive.

126. Later, after respondent had switched Patient 7 from oxcarbazepine to valproic acid because of the rash described in Finding 119, Patient 7 did have further EEG studies that showed more generalized epileptiform activity (as summarized in Finding 117). Dr. Sarco opines that respondent committed extreme departures from the standard of care both by describing Patient 7's abnormal electrical activity as

epilepsy and by prescribing valproic acid to treat it. In light of the matters summarized in Findings 121 and 124, however, this opinion is not persuasive.

127. On several occasions, Patient 7 arrived at respondent's office with a headache. Respondent's records indicate that Patient 7 received mild hyperbaric oxygen treatment and reported that it helped. The records also indicate that respondent advised Patient 7's mother to keep a journal that might reveal any pattern to Patient 7's headaches, but not that she ever did so. Dr. Sarco opines that respondent committed extreme departures from the standard of care both by describing these headaches in his records as "cluster" headaches and by failing to conduct a full and appropriate evaluation to diagnose and possibly prevent them. In light of the diagnostic procedures and medical treatment Patient 7 already was receiving, however (summarized in Findings 114 through 122), Dr. Sarco's opinion that respondent should have done something for Patient 7's reported headaches beyond treating them symptomatically is not persuasive.

128. Dr. Sarco states that respondent committed a simple departure from the standard of care for Patient 7 by diagnosing "oppositional defiant disorder" without referring Patient 7 to any mental health care provider. In light of the matters stated in Findings 115, 120, and 123, this unsupported opinion is not persuasive.

Adult Patient Care Allegations

129. Complainant also alleges that respondent treated two adult patients in an unprofessional manner during 2017, 2018, and 2019.

130. With respect to these adult patients, complainant presented expert testimony from neurologist Jeremy L. Hogan, M.D. Dr. Hogan is board-certified in adult neurology, headache medicine, and electrodiagnostic medicine. He is a member

of a multi-specialty medical group where he treats primarily adults, and he also trains neurology residents and fellows at the San Diego Veterans' Administration Hospital. For several years, Dr. Hogan has conducted training programs specifically to teach neurologists the best practices in using botulinum toxin to treat headaches. Respondent presented his own testimony as well as testimony from Dr. Frye.

PATIENT 8

131. Patient 8 came to respondent on her primary care physician's recommendation in March 2017. She reported at her first visit that someone had kicked her several times in the head about six months earlier, and that she continued to experience disabling symptoms including headaches, memory problems, emotional lability, and sensitivity to noise and light. In addition, about four years earlier Patient 8 had undergone cervical disk replacement surgery. She said that she already had seen a different neurologist, and respondent testified credibly that he recalls that she came to him specifically with an interest in mild hyperbaric oxygen therapy.

132. No medical records about Patient 8 other than respondent's records are in evidence. Moreover, respondent's records about Patient 8 are incomplete. No medical notes are in evidence for the period between April 4, 2017, and November 2, 2017, even though billing records and correspondence in evidence show respondent to have provided treatment to Patient 8 during this period. Similarly, after the medical note in evidence from November 3, 2017, the next note in chronological order is from June 13, 2018, despite billing records suggesting that respondent rendered service to Patient 8 between these dates. No witness addressed these omissions, which make respondent's records regarding Patient 8 inadequate and inaccurate.

133. Respondent provided mild hyperbaric oxygen therapy to Patient 8 numerous times between March 2017 and September 2018. His records state that she told him that it helped on several occasions to resolve acute headaches, although the records do not provide enough information to support a conclusion that these treatments improved Patient 8's long-term health.

134. Dr. Hogan acknowledges that some studies have suggested that oxygen treatments may be potentially beneficial for people with post-concussive symptoms. He believes nevertheless that use of oxygen in this context is so unusual that it constitutes a simple departure from the standard of care. Respondent's records about Patient 8 show that he did not rely solely on mild hyperbaric oxygen to treat her, however, and the records along with the matters stated in Findings 26 and 27 do not show that these treatments exposed Patient 8 to any significant risk of harm. Dr. Hogan's opinion that respondent departed from the standard of care by providing mild hyperbaric oxygen to Patient 8 is not persuasive.

135. In addition to treating Patient 8 with mild hyperbaric oxygen, respondent prescribed medication to her and advised her to rest as much as possible. Because of the omissions described in Finding 132, details about Patient 8's course of treatment between April 2017 and June 2018 are not clear. Every visit note that is in evidence describes headaches, which sometimes were so severe that Patient 8 visited a hospital emergency room. The only pattern noted is that Patient 8 often woke up in the morning with a headache, which would resolve in part and then return later in the day.

136. Respondent's notes describe Patient 8's headaches as "chronic cluster and migraine headaches likely associated with post concussion disorder." He also noted that tension in Patient 8's neck sometimes triggered a headache, and listed "Occipital Neuralgia" among his working diagnoses.

137. Dr. Hogan testified credibly and persuasively that "cluster" and "migraine" headaches, and occipital neuralgia, are distinct primary disorders, not simply ways to describe the patient's experience with post-concussion headaches. He also testified credibly and persuasively that a neurologist treating a patient with disabling headaches that persist as often and over as long a duration as Patient 8's headaches did should document carefully the frequency, duration, circumstances, and characteristics of the headaches. Dr. Hogan characterized respondent's treatment of Patient 8's headaches as reflecting a lack of knowledge about best practices in headache management, and this opinion is persuasive.

138. In June 2018, respondent recommended botulinum toxin injections to Patient 8 as a headache treatment. She had her first such injections on June 27, 2018; respondent documented the treatment as "100 units . . . diluted to 5 units per 0.1 mL and injected in the glabella, temporal region, frontalis, occipital region, and trapezius bilaterally." Patient 8 had a second set of botulinum toxin injections on September 21, 2018, which respondent documented in the same manner.

139. Dr. Hogan believes that botulinum toxin injections were within the standard of care for Patient 8. But he also believes that respondent committed simple departures from the standard of care regarding these injections by failing to document the injection sites with adequate specificity, by failing to document exactly how much botulinum toxin he injected into each site, by failing to document having given Patient 8 full information about the treatment's risks and benefits, and by using only 100 units of botulinum toxin rather than the standard dose of 155 units.

140. Dr. Frye testified credibly that in using botulinum toxin to treat headaches, the "exact amount used varies by clinical option and expertise." Respondent also testified credibly that Patient 8's insurance carrier would approve

only 100 units for her, not 155. As to the amount of botulinum toxin respondent used for Patient 8, Dr. Hogan's critique is not persuasive.

141. The remainder of Dr. Hogan's opinion about respondent's botulinum toxin treatments for Patient 8 is credible and persuasive, however. Respondent's records document only a general discussion about the treatment, not specific information about its potential risks and benefits and not clear consent by Patient 8 to receive the treatment despite its risks. The locations respondent described localize the injections generally on the scalp but identify only two of the muscles[12] he injected (the frontalis and trapezius) and identify none of the locations precisely. And respondent's records do not identify how many units of botulinum toxin respondent put into each location. Although these documentation omissions do not show that respondent misused botulinum toxin for Patient 8 or underinformed her about it before she consented to it, Dr. Hogan's opinion is persuasive that the omissions are simple departures from the standard of care.

142. Respondent recommended and performed an EEG for Patient 8 in August 2017. Because his records do not include notes from this period, they do not explain precisely why respondent recommended the EEG. According to Dr. Hogan, "[p]erforming an EEG on a patient with a traumatic brain injury but no complaints of possible seizures represents a simple departure from the standard of care." Respondent and Dr. Frye agreed that an EEG is not necessary to evaluate every person suffering lingering consequences from a head injury, but that the memory concerns about which Patient 8 complained were reason in such a patient to perform one. Although Dr. Hogan's opinion is somewhat persuasive, this difference in medical

[12] Botulinum toxin works by impairing muscle contraction.

judgment is not significant enough to make his opinion more clearly and convincingly persuasive than Dr. Frye's.

143. Respondent testified credibly that he read the EEG and prepared a report, but that he does not know why that report is no longer in his medical record about Patient 8. Dr. Hogan testified persuasively to the opinion that failing to maintain an EEG report is a simple departure from the standard of care.

144. Finally, Dr. Hogan opines that respondent departed from the standard of care by including billing codes in his records for Patient 8 reflecting "inhalation treatments" and "assessing mental health problems." Respondent's records confirm, however, that he administered mild hyperbaric oxygen to Patient 8, and he testified credibly that he uses the code for "inhalation treatments" in his records to refer to this therapy. In addition, respondent's records confirm that he assessed Patient 8's mental health on several occasions, advising her about anxiety and stress and their potential relationship to her continuing headaches. No evidence establishes how respondent or his administrative staff members may have used the codes in Patient 8's records to prepare bills for Patient 8 or her insurance providers; and like Dr. Sarco, Dr. Hogan acknowledged that his medical expertise is clinical, not administrative. His criticism of respondent's use of billing codes in recordkeeping is not persuasive.

PATIENT 9

145. Patient 9 came to see respondent on September 16, 2019. Respondent's records do not reflect whether she chose him herself, or received a referral from someone else. They do reflect that Patient 9 described having seen a psychiatrist in the past but did not describe a current relationship with a psychiatrist.

146. Patient 9 characterized her chief complaint as extreme insomnia, with nightmares. She also reported, according to respondent's notes, that she had experienced a "convulsive seizure after not sleeping for a number of days in a row." Respondent described Patient 9 as "hypomanic," with "pressured speech," and noted that she took "most of the visit to explain all the history about her extremely abusive relationship with her father."

147. Respondent recommended an EEG for Patient 9, and advised "continued counseling." He also noted in his plan that he would obtain "additional history from other providers if possible." At no time during their brief relationship did Patient 9 identify any other providers or prior diagnoses to respondent, however.

148. Patient 9 had an EEG on September 19, 2019. It showed what respondent described as "generalized slowing," which he attributed to Patient 9's regular use of a prescription benzodiazepine drug as a sleep aid. Patient 9 did not experience any "clinical seizure activity" or "epileptiform discharges" during the EEG.

149. On September 23, 2019, respondent saw Patient 9 again. He told her that the EEG was abnormal in a manner likely reflecting her benzodiazepine use, and that his overall impression was that she "clearly fits a diagnosis of bipolar [disorder] with psychotic features due to the endorsement of hallucinations, pressured speech, and routine intrusive thoughts." Respondent recommended that Patient 9 begin taking oxcarbazepine "at mood stabilization dose."

150. Patient 9 took great offense to respondent's diagnosis and advice. She did not return to respondent, and later filed a complaint with the Board accusing him (in rambling, tangential language) of arrogantly disregarding the diagnoses Patient 9 had received from her "sleep doctor" and her psychiatrist.

151. Dr. Hogan believes that a neurologist such as respondent may have the expertise to diagnose bipolar disorder, and he did not testify to the opinion that respondent had erred in concluding that Patient 9 had this mental illness. Dr. Hogan testified, however, that he believes respondent committed a simple departure from the standard of care by prescribing oxcarbazepine to Patient 9 rather than referring her to a psychiatrist for further evaluation and treatment.

152. Respondent testified credibly that he believed Patient 9 to be "very obviously compromised," and in urgent need of both appropriate medication and sleep. He would have recommended immediate psychiatric hospitalization to her if he had believed she would accept that recommendation. Because he did not believe she would accept it, he elected to prescribe oxcarbazepine to her rather than sending her away with a recommendation to consult a different specialist.

153. Dr. Hogan's opinion that Patient 9 was in greater need of psychiatric than neurological care is persuasive, and conforms to respondent's own conclusions as reflected in his testimony and records. In light of the matters stated in Findings 146, 149, and 152, however, Dr. Hogan's opinion that respondent departed from the standard of care by prescribing to Patient 9 in the hope that he could help her in the short term while cooperating with other providers to care for her over the longer term is not persuasive.

Other Allegations

154. Complainant alleges three other types of unprofessional conduct that do not relate to respondent's care for any particular patient.

BODYLAB MED SPA

155. In addition to treating patients for neurological concerns, respondent also provides cosmetic procedures using the Board-approved fictitious name, "Bodylab Med Spa." These procedures include dermal fillers, cosmetic injections of botulinum toxin, and cryolipolysis using the CoolSculpting branded device.

156. Respondent's wife, Stacey Boscoe, is trained as a medical assistant but is not licensed to practice any health care profession. She holds Esthetician License No. 140689 from the California Board of Barbering and Cosmetology, which authorizes her to perform non-medical cosmetic procedures such as facial cleansing and exfoliating, eyelash and eyebrow tinting, and hair removal through tweezing or waxing. Boscoe also holds Barbering and Cosmetology Establishment License No. 344931, authorizing her to perform these procedures in a designated portion of the office building that houses respondent's medical practice and the Bodylab Med Spa. Finally, Boscoe holds a license through the County of Santa Cruz to perform tattooing at this location, which she testified she uses primarily to provide areola tattoos to clients who have undergone breast reconstruction surgery.

157. Respondent and Boscoe testified consistently and credibly about the Bodylab Med Spa services and their respective roles in providing those services. No records for any Bodylab Med Spa patients or clients are in evidence, and no such patients or clients testified.

158. Respondent began offering CoolSculpting in 2017. The device's vendor would sell the device only to a licensed medical professional, but represented to respondent at that time that properly trained but unlicensed medical assistants

lawfully and safely could operate the device, under direction but not necessarily personal supervision by a licensed medical professional.

159. Respondent, Boscoe, and medical assistant Estefania Mendoza all received training from the CoolSculpting device's vendor about how to perform cryolipolysis using the device. After they had completed an online course about the principles, benefits, and risks of the cryolipolysis procedure, a vendor representative came to the office to train them in person. Boscoe also has taken a marketing course from the vendor on how to build and promote a CoolSculpting practice.

160. Some Bodylab Med Spa clients come only for non-medical services, and Boscoe provides primary service to these clients. If potential clients need information about the medical and non-medical options that are available to meet their cosmetic objectives, Boscoe orients those people to the services that she and respondent offer. Respondent examines every patient who seeks medical cosmetic services, counsels them about appropriate and inappropriate services and about medical risks, and performs services that are beyond the practice scope of Boscoe's Barbering and Cosmetology license.

161. The evidence includes very little information about how cryolipolysis or the CoolSculpting device work. The procedure involves using a cold medium to eliminate subcutaneous body fat, and it does not involve either injections or incisions. No evidence establishes whether the procedure involves cold room air, another cold gas, cold water, or some other medium; no evidence establishes how cold the medium is, how the device cools it, or how the cold medium contacts the patient's skin; no evidence establishes the procedure's most common risks, treatment failures, or unintended effects; no evidence establishes how long a typical treatment takes or how many treatments a typical patient receives; and no evidence establishes how a

provider develops and implements a CoolSculpting treatment plan to achieve the patient's cosmetic objectives.

162. When respondent got the CoolSculpting device in 2017, respondent and Boscoe understood, based on the vendor's representations summarized in Finding 158 and the training summarized in Finding 159, that cryolipolysis using the CoolSculpting device was a procedure that Boscoe could plan, counsel to clients, and perform without respondent's personal supervision. She did, receiving recognition from the device vendor as one of her region's leading CoolSculpting providers.

163. In late 2019 or early 2020, respondent and Boscoe became aware that some Board staff members believed that cryolipolysis using the CoolSculpting device was a medical procedure that an unlicensed medical assistant could not perform without a physician's personal supervision. In addition, at about this same time, respondent and Boscoe became aware that the device's vendor had changed its advice to providers, no longer advising that unlicensed persons could lead CoolSculpting treatments with only general direction by a physician and stating instead that the vendor could not advise users on this issue. Boscoe stopped providing CoolSculpting treatments, although she continues to advise prospective clients about the procedure. Respondent now examines every potential CoolSculpting patient and plans and administers the patients' treatments.

164. Complainant presented expert testimony by board-certified plastic surgeon Michael A. Bain, M.D., about CoolSculpting. Dr. Bain testified to his opinion that the CoolSculpting device is a medical device that requires a licensed medical professional's personal participation in every aspect of patient counseling, treatment planning, and device use. Because no evidence explained how the device works, what

its risks may be, or how provider training and licensure may mitigate some or all of those risks, this opinion is not persuasive.

165. Dr. Bain also testified to his opinion that even if respondent involves himself personally in CoolSculpting procedures, he cannot do so competently because he has not received appropriate training. This opinion is contrary to the facts, as summarized in Finding 159, and is not persuasive.

REPRESENTATIONS REGARDING QUALIFICATIONS

166. Respondent maintains an Internet website describing his medical practice. As of late 2020, the website stated that respondent "Specializes in Neurology with specific qualifications in Child Neurology." It did not state that respondent was certified by any board or organization as a specialist in any medical field.

167. The website also included a short biography, which stated that respondent had "completed an internship in pediatrics . . . and fellow ship in neurology at Stanford University." Calling the residency described above in Finding 6 a fellowship is not inaccurate, in light of the matters stated in Finding 7. By implying that respondent participated in the full usual course of that residency or fellowship, however, rather than only half of it, the statement that he "completed" the fellowship carries a reasonable probability of deceiving a reader about respondent's postgraduate medical training.

168. The evidence does not establish that any person ever actually read the biographical statement summarized in Finding 167 and believed respondent to have graduated from the child neurology residency described above in Finding 6. In addition, the evidence does not establish whether respondent still maintained the

same practice website at the time of the hearing, or if so whether it still states that he "completed" a neurology fellowship.

SELF-PRESCRIBING

169. During the course of investigating respondent's medical practice, a Board investigator obtained a report from the Controlled Substance Utilization Review and Evaluation System (CURES) about controlled substance prescriptions issued to respondent. The report showed that respondent had prescribed lorazepam, testosterone, and Ketalar or ketamine to himself regularly but not frequently between July 2017 and July 2020. On all occasions except one, a pharmacy called Medical Clinic Pharmacy filled the prescriptions; on one occasion, respondent obtained the medication (ketamine) from Horsnyder Pharmacy.

170. Licensed pharmacist Thomas Dembski, the indirect owner of Medical Clinic Pharmacy, testified credibly about his business relationship with respondent. He also provided records corroborating his testimony. Dembski explained that respondent ordered medication from Medical Clinic Pharmacy for in-office administration to patients, such as lorazepam to relieve anxiety in a patient undergoing a painful diagnostic procedure. In each case, the prescription order states that respondent requested the medication for "office use." Dembski explained that his pharmacy had miscoded these prescriptions in its reports to the CURES database as if the pharmacy had dispensed the medications to respondent for personal use, and that he had realized only after receiving an inquiry about this matter that Medical Clinic Pharmacy should not have reported these prescriptions to CURES.

171. No representative from Horsnyder Pharmacy testified, but the pharmacy provided documents showing that on the one occasion when respondent obtained medication there he also indicated that he wanted the medication for in-office use.

172. Respondent also testified about this issue, credibly and in a manner consistent with Dembski's testimony. He explained that he uses controlled substances in his office that he obtains from local pharmacies by writing prescriptions to himself and specifying that the drugs will be for office use. He does not dispense controlled substances from his office for patients to consume at home, and he has never prescribed controlled substances to himself for his own use.

Additional Evidence

173. In addition to his clinical medical practice, respondent continues to perform laboratory research in neurology and metabolism.

174. For several years, respondent has offered internships in his medical practice to undergraduate students at the University of California, Santa Cruz. Interns accompany him in patient care and review relevant medical literature. Two of respondent's interns have gone on to medical school.

175. At the time respondent treated the nine patients whose care is at issue in this matter, he used an electronic medical record-keeping system that he now thinks was "pretty awful." He has changed systems since that time and considers the new system much easier to use and more complete.

176. Respondent testified credibly that his diagnostic and treatment protocols, his documentation practices, and his use of mild hyperbaric oxygen did not

change materially between 2014 (when he began his Board probation, including his participation in the post-PACE performance enhancement program) and 2020.

References

177. Respondent presented testimony from several professional colleagues and patients, as well as letters from many patients.

COLLEAGUES

178. Lawrence Steinman, M.D., has been a faculty member at Stanford University since 1980. He is a neurologist who treats both adult and pediatric patients. Dr. Steinman knows respondent from respondent's Stanford University residency, and holds respondent "in very high regard." After respondent's termination from the residency program (described above in Findings 6, 7, and 13) and before respondent reported to serve his prison sentence, respondent worked in Dr. Steinman's research laboratory. They have continued to collaborate on research since that time.

179. Licensed Clinical Social Worker Neil D. Brown is in private practice, emphasizing treatment for families with adolescent or young adult members in social or psychological crisis. He has known respondent for several years and has shared numerous patients with him. Brown often refers patients to respondent for insight into medical neurological problems that may influence the patient's maladaptive behavior, and respondent likewise refers patients to Brown for non-medical mental health care. Brown has no reservations about respondent's medical judgment and appreciates respondent's openness to consultation and collaboration.

180. Licensed Clinical Psychologist Gerard Chambers, Psy.D., Ph.D., testified as well regarding sharing patients with respondent. Dr. Chambers noted that he and

respondent both treat many patients with autism spectrum disorder; often, respondent performs neurological examinations and medication management for these patients while Dr. Chambers provides diagnostic assessments and recommendations for non-medical therapies.

181. Estefania Mendoza has worked as a medical assistant in respondent's practice for several years. As described above in Finding 159, she received cryolipolysis training; in addition, respondent trained her as an EEG technician. Mendoza also has served as the practice's usual interpreter for Spanish-speaking patients and families. Mendoza considers respondent very polite and thorough, noting that he often extended patient visits "overtime" when necessary to ensure that he had explained medical issues fully. Mendoza also has been respondent's patient, receiving treatment she considered effective for headaches and ADHD.

182. Gary Geil, M.D., provided a letter regarding his interactions with respondent as a "neuroradiologist reviewing imaging studies on his patients." Dr. Geil notes that respondent does not simply send Dr. Geil studies to review, but has on occasion called Dr. Geil "to discuss these imaging studies at great length." Because he respects respondent's skill, Dr. Geil also has consulted respondent as a patient.

PATIENTS

183. Clinton Louis Stine, Jr., has been respondent's acquaintance since approximately 2016, and his patient since approximately 2019. Stine testified that he had "never had a healthy medical relationship" before meeting respondent, but that he valued respondent's thoughtful and respectful approach to care. Stine also has provided interpreting services for respondent (between American Sign Language and

English) and appreciated respondent's efforts to ensure that the patient and family understood all information about the patient's condition and care.

184. Dr. Chambers and his wife also have been respondent's patients. Dr. Chambers believes respondent's care was very effective for his wife's chronic headaches. For Dr. Chambers, respondent successfully treated "a nerve problem" in Dr. Chambers's ankle. In addition, when Dr. Chambers consulted respondent regarding unusual fatigue, respondent pushed Dr. Chambers to obtain a sleep study that led to resolution.

185. Respondent offered numerous other positive letters from patients and patients' parents.

Costs

186. Since January 1, 2022, the Board has incurred $76,328.75 in costs for legal services provided to complainant by the California Department of Justice in this matter. Complainant's claim for reimbursement of these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(2).

187. For at least two reasons, the total cost amount stated in Finding 186 is unreasonable. First, because personnel assigned to this matter changed several times over the period between January 1, 2022, and the hearing date, the cost total reflects considerable repetition of effort. Second, the Department of Justice devoted significant labor to preparing and presenting evidence at hearing about matters as to which that evidence was clearly insufficient to support complainant's allegations. A reasonable cost for the services provided by the Department of Justice to complainant in this matter since January 1, 2022, is $35,000.

LEGAL CONCLUSIONS

1. The Board may take disciplinary action against respondent only if clear and convincing evidence establishes cause for such action. The factual findings above rest on clear and convincing evidence.

Alleged Causes for Discipline, Patient Care

2. The Board may suspend or revoke respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes medical practice reflecting gross negligence, repeated negligence, incompetence, or dishonesty. (*Id.*, § 2234, subds. (b), (c), (d), (e).) It also includes failure to maintain adequate and accurate medical records (*id.*, § 2266), and maintaining medical records that include falsehoods (*id.*, § 2261).

FIRST CAUSE FOR DISCIPLINE (PATIENT 1)

3. Complainant alleges 11 specific ways in which respondent's treatment for Patient 1 was unprofessional: (A) performing a lumbar puncture; (B) diagnosing autoimmune encephalitis; (C) prescribing hyperbaric oxygen; (D) mistreating headaches; (E) misinterpreting EEGs; (F) prescribing inappropriate medications; (G) prescribing too much lamotrigine and too little oxcarbazepine; (H) considering only a short-term trial of oxcarbazepine; (I) mistreating hypersomnia; (J) using inappropriate billing codes; and (K) duplicating medical notes.

4. The matters stated in Findings 25, 28 through 30, 40, 41, 43, 45, 47, 48, and 50 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 1.

SECOND CAUSE FOR DISCIPLINE (PATIENT 2)

5. Complainant alleges 12 specific ways in which respondent's treatment for Patient 2 was unprofessional: (A) prescribing hyperbaric oxygen; (B) ordering multiple EEGs; (C) misinterpreting EEGs; (D) misdiagnosing absence epilepsy; (E) prescribing oxcarbazepine; (F) mistreating microcephaly; (G) documenting developmental screening that did not occur; (H) billing for services he did not render; (I) duplicating medical notes; (J) speaking disrespectfully to Patient 2's mother; (K) misdiagnosing autism spectrum disorder and ADHD; and (L) mistreating shortness of breath.

6. The matters stated in Findings 25, 28 through 30, 61, 63, 64, 66 through 68, and 70 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 2.

THIRD CAUSE FOR DISCIPLINE (PATIENT 3)

7. Complainant alleges seven specific ways in which respondent's treatment for Patient 3 was unprofessional: (A) misdiagnosing epilepsy; (B) misdiagnosing anxiety; (C) ordering multiple EEGs; (D) misinterpreting EEGs; (E) prescribing oxcarbazepine; (F) documenting developmental screening that did not occur; and (G) duplicating medical notes.

8. The matters stated in Findings 25, 29, 30, 72, 73, and 75 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 3.

FOURTH CAUSE FOR DISCIPLINE (PATIENT 4)

9. Complainant alleges seven specific ways in which respondent's treatment for Patient 4 was unprofessional: (A) and (D) misdiagnosing epilepsy; (B) ordering

multiple EEGs; (C) misinterpreting EEGs; (E) prescribing oxcarbazepine; (F) misdiagnosing ADHD, anxiety, and OCD ; (G) billing for services he did not render; and (H) duplicating medical notes.

10. The matters stated in Findings 25, 29, 30, 78, 79, 82, and 83 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 4.

SEVENTH CAUSE FOR DISCIPLINE (PATIENT 5)

11. Complainant alleges four specific ways in which respondent's treatment for Patient 5 was unprofessional: (A) misinterpreting EEGs; (B) prescribing lamotrigine too aggressively; (C) failing to provide appropriate epilepsy counseling; and (D) speaking disrespectfully to Patient 5's mother.

12. The matters stated in Findings 88, 89, 91, and 92 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 5.

EIGHTH CAUSE FOR DISCIPLINE (PATIENT 6)

13. Complainant alleges 11 specific ways in which respondent's treatment for Patient 6 was unprofessional: (A) misdiagnosing absence epilepsy; (B) ordering multiple EEGs; (C) misinterpreting EEGs; (D) and (E) prescribing oxcarbazepine; (F) prescribing hyperbaric oxygen; (G) diagnosing mental illnesses; (H) ordering an "unjustified" MRI; (I) failing to advise regarding low Vitamin D; (J) mistreating microcephaly; (K) speaking disrespectfully to Patient 6's mother; and (L) duplicating medical records.

14. The matters stated in Findings 28, 29, 101, 105 through 107, and 110 through 113 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 6.

NINTH CAUSE FOR DISCIPLINE (PATIENT 7)

15. Complainant alleges seven specific ways in which respondent's treatment for Patient 7 was unprofessional: (A) misdiagnosing absence epilepsy; (B) ordering multiple EEGs; (C) misinterpreting EEGs; (D) and (E) prescribing oxcarbazepine; (F) mistreating headaches; (G) prescribing hyperbaric oxygen; and (H) diagnosing mental illnesses.

16. The matters stated in Findings 28, 118, and 125 through 128 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to Patient 7.

TENTH CAUSE FOR DISCIPLINE (PATIENT 8)

17. Complainant alleges seven specific ways in which respondent's treatment for Patient 8 was unprofessional: (A) ordering an EEG; (B) failing to maintain complete medical records; (C) using oxygen to treat post-concussive syndrome; (D) failing to keep adequate records regarding use of botulinum toxin; (E) underutilizing botulinum toxin; (F) mistreating headaches; and (G) billing for services he did not render.

18. As summarized in Findings 132, 137, 141, and 143, respondent's documentation and medical records regarding Patient 8 were not complete, and his treatment of Patient 8's headaches reflected poor knowledge. These matters constitute cause for discipline against respondent under Business and Professions Code sections 2234, subdivision (c) (repeated negligence), and 2266 (inadequate records).

19. The matters stated in Findings 134, 140, 142, and 144 do not support complainant's other allegations of unprofessional conduct with respect to Patient 8.

ELEVENTH CAUSE FOR DISCIPLINE (PATIENT 9)

20. Complainant alleges that respondent acted unprofessionally with respect to Patient 9 by diagnosing and attempting to treat her for psychiatric illness.

21. As summarized in Findings 146 through 152, respondent did diagnose a psychiatric illness in Patient 9, and prescribed medication to her that he believed would improve her condition. The matters stated in Finding 153 do not support the allegation that these acts were unprofessional, however. Clear and convincing evidence does not establish cause for discipline with respect to Patient 9.

Other Alleged Causes for Discipline

22. The remaining alleged causes for discipline against respondent relate not to his care for individual patients but to the manner in which he conducts his business.

FIFTH CAUSE FOR DISCIPLINE (FALSE STATEMENTS)

23. Business and Professions Code sections 651 and 2271 forbid physicians to advertise in a "false or misleading" manner, and section 2234, subdivision (e) states that dishonesty is unprofessional conduct. The matters summarized in Findings 166 through 168 do not establish any deliberate dishonesty by respondent, but these matters do establish that respondent's website in 2020 included a statement about his postgraduate medical training that would have been likely to mislead a reasonable reader. That statement is cause for discipline under Business and Professions Code sections 651 and 2271.

SIXTH CAUSE FOR DISCIPLINE (BODYLAB MED SPA)

24. Complainant contends that respondent committed unprofessional conduct by permitting unlicensed persons to perform CoolSculpting treatments, and by purporting to supervise those treatments without adequate training of his own. Complainant contends as well that this activity violated Business and Professions Code section 2264, because it aided and abetted Boscoe's unlicensed medical practice. Finally, complainant contends that respondent and Boscoe kept inadequate medical records, in violation of Business and Professions Codes 2266, because Boscoe's lack of medical licensure made her unable to keep medically adequate records.

25. The matters stated in Findings 155 through 165 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to the Bodylab Med Spa.

TWELFTH CAUSE FOR DISCIPLINE (PRESCRIBING)

26. Complainant contends that respondent committed unprofessional conduct and violated numerous statutes relating to controlled substances, both by prescribing these substances to himself and by dispensing them to patients without appropriate documentation.

27. The matters stated in Findings 169 through 172 do not support these allegations. Clear and convincing evidence does not establish cause for discipline with respect to controlled substance prescribing.

Disciplinary Considerations

28. Since 2014, respondent has practiced medicine under continuous supervision or investigation by the Board. He has cooperated fully in all such efforts,

which have yielded no evidence that his medical practice or judgment are incompetent, dishonest, or unconventional.

29. Complainant failed to produce even a preponderance of evidence, let alone clear and convincing evidence, supporting most of complainant's allegations in this matter. On some issues, however, complainant produced evidence that is persuasive but not clear and convincing. These issues may represent opportunities for respondent to improve his practice, his judgment, or his cooperation with other specialists even though they do not constitute cause for discipline under the evidentiary standards that apply to this matter.

30. Complainant establishes cause for discipline only for simple departures from the standard of care and inadequate records for one patient, and for one potentially misleading statement that appeared on respondent's website in 2020. Complainant does not establish either that harm occurred to any patient or that the circumstances constituting cause for discipline persist or will recur. These issues do not warrant the financial or practical challenges that an additional probation term would impose either on respondent or on the Board. A public reprimand is adequate to express the Board's disapproval of respondent's conduct and to protect the public against its repetition.

Costs

31. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Finding 187 establish that the reasonable costs for this matter total $35,000.

32. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*)

33. All these matters have been considered. Respondent's successful challenge to most of the allegations against him justifies reduction of his reimbursement obligation to $3,500.

ORDER

1. Physician's and Surgeon's Certificate No. A 118089, held by respondent William J. Zinnanti, M.D., Ph.D., is hereby publicly reprimanded.

2. Respondent must pay $3,500 to the Board, to reimburse the Board for its enforcement costs in this matter, within 30 days after the effective date of this order.

DATE: 10/10/2023

Juliet E. Cox

JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings