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

In the Matter of the Accusation Against: Mark Daniel Cook, M.D. Physician's and Surgeon's Certificate No. A 60965 Respondent.	Case Nos.: 800-2017- 039585, 800-2020-072482, 800-2021-083681

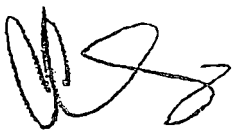
DECISION

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

This Decision shall become effective at 5:00 p.m. on April 24, 2024.

IT IS SO ORDERED: March 25, 2024.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against: **MARK DANIEL COOK, M.D.** **1425 West H St. Ste. 200** **Oakdale, CA 95361** **Physician's and Surgeon's Certificate No. A 60965** Respondent.	Case No. 800-2017-039585 OAH No. 2021010154 Case No. 800-2020-072482 OAH No. 2023030746 Case No. 800-2021-083681 OAH No. 2023080549 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought these actions solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Michael C. Brummel, Supervising Deputy Attorney General.

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2. Respondent Mark Daniel Cook, M.D. (Respondent) is represented in this proceeding by attorney Robert F. Hahn, whose address is 2550 Ninth Street, Suite 101, Berkeley, CA 94710-2551.

3. On or about October 2, 1996, the Board issued Physician's and Surgeon's Certificate No. A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-039585, and will expire on August 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-039585 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on October 8, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. First Amended Accusation No. 800-2017-039585 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on December 9, 2022, and was deemed controverted pursuant to Government Code Section 11507 in light of the fact that Respondent timely filed his Notice of Defense contesting the original Accusation No. 800-2017-039585. A copy of First Amended Accusation No. 800-2017-039585 is attached as Exhibit A and incorporated herein by reference.

5. Accusation No. 800-2020-072482 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 17, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-072482 is attached as Exhibit B and incorporated herein by reference.

6. Accusation No. 800-2021-083681 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on July 13, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. First Amended Accusation No. 800-2021-083681 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on November 30, 2023, and was deemed controverted pursuant to

Government Code Section 11507 in light of the fact that Respondent timely filed his Notice of Defense contesting the original Accusation No. 800-2021-083681. A copy of First Amended Accusation No. 800-2021-083681 is attached as Exhibit C and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

10. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

11. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, and that Respondent hereby gives up his right to contest those charges.

12. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, a true and correct copy of each is attached hereto as Exhibit A, Exhibit B, and Exhibit C, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 60965 to disciplinary action.

13. ACKNOWLEDGMENT. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

14. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

16. This Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-

083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 60965 issued to Respondent Mark Daniel Cook, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for ten (10) years on the following terms and conditions:

1. PATIENT DISCLOSURE. Before a patient's first visit following the effective date of this order and while the respondent is on probation, the respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the respondent's probation on the respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct

treatment relationship with the patient.

2. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 60 days beginning the sixteenth (16th) day after the effective date of this decision.

3. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules III, IV, and V of the Act. Upon successful completion of the prescribing practices course described in Condition 6, this restriction shall be lifted and Respondent may prescribe controlled substances as permitted by the DEA.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

4. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

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

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

complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

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

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

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

9. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate Respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, Respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not Respondent successfully completed the program.

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

Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

10. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

11. MONITORING – PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to

cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

12. THIRD PARTY CHAPERONE. During probation, Respondent shall have a third party chaperone present while consulting, examining or treating female patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If Respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its

designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If Respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

Respondent shall provide written notification to Respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with female patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times

during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

13. PROHIBITED PRACTICE. During probation, Respondent is prohibited from practicing or attempting to practice, advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other physical or mental condition of any person as set for in Business and Professions Code Section 2052, on any persons that are related to him by blood, marriage, or reside with him. After the effective date of this Decision, all persons being treated by the Respondent shall be notified that the Respondent is prohibited from practicing or attempting to practice, advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other physical or mental condition of any person as set for in Business and Professions Code Section 2052, on any persons that are related to him by blood, marriage, or reside with him. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

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

Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

17. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $200,000.00 (two hundred thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California not to exceed three years. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs (if applicable).

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

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

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19. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

21. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

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

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

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

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

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

22. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical

Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

25. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

26. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First

Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert F. Hahn. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

MARK DANIEL COOK, M.D.
Respondent

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

DATED: _____

ROBERT F. HAHN
Attorney for Respondent

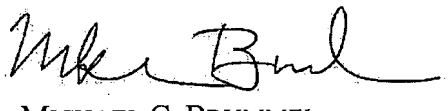
ENDORSEMENT

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

DATED: December 29, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General



MICHAEL C. BRUMMEL
Supervising Deputy Attorney General
Attorneys for Complainant

FR2020300931
95546423

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert F. Hahn. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/29/23

MARK DANIEL COOK, M.D.
Respondent

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

DATED: 12/29/23

ROBERT F. HAHN
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-039585

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
MICHAEL C. BRUMMEL
Deputy Attorney General
State Bar No. 236116
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Mark Daniel Cook, M.D.** **1425 West H St. Ste. 200** **Oakdale, CA 95361** **Physician's and Surgeon's Certificate No. A 60965,** Respondent.	Case No. 800-2017-039585 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 729 defines sexual exploitation by physicians, and others, and states:

> (a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor is a public offense:

(1) An act in violation of subdivision (a) shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the offender has no prior conviction for sexual exploitation, shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(3) An act or acts in violation of subdivision (a) with two or more victims shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(4) Two or more acts in violation of subdivision (a) with a single victim, when the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(5) An act or acts in violation of subdivision (a) with two or more victims, and the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000).

For purposes of subdivision (a), in no instance shall consent of the patient or client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

(1) "Psychotherapist" has the same meaning as defined in Section 728.

(2) "Alcohol and drug abuse counselor" means an individual who holds himself or herself out to be an alcohol or drug abuse professional or paraprofessional.

(3) "Sexual contact" means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in Section 243.4 of the Penal Code.

(d) In the investigation and prosecution of a violation of this section, no person shall seek to obtain disclosure of any confidential files of other patients, clients, or former patients or clients of the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in a professional partnership or similar group has sexual contact with a patient in violation of this section, another physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in the partnership or group shall not be subject to action under this section solely because of the occurrence of that sexual contact.

6. Section 726 defines sexual abuse, misconduct, or relations with a patient or others, and states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division or under any initiative act referred to in this division.

(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

7. Excessive prescription or administration of drugs is defined in Section 725, and states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

8. Unprofessional conduct is defined in Section 2234, and states:

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

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

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

9. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

10. Section 2228.1, subdivision (a)(1)(A) provides the means for a licensee to disclose probation status, and states, in pertinent part,

"...the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

11. Section 2246 states: Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case[1], with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

13. Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall® and other stimulants are contraindicated for patients with a history of drug abuse.

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[1] As of November 18, 2021, Section 125.3 of the Code has been amended to remove subsection (k), which precluded the Board from collecting costs. The Board may collect investigation, prosecution, and other costs incurred for a disciplinary proceeding against a licensee beginning January 1, 2022.

14. Quetiapine (Seroquel XR®) is indicated in adults for (1) adjunctive therapy to antidepressants in major depressive disorder; (2) acute depressive episodes in bipolar disorder; (3) acute manic or mixed episodes in bipolar I disorder, as either monotherapy or adjunct therapy to lithium or divalproex; (4) maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex; and (5) schizophrenia. It is also indicated in children and adolescents (10-17 years) for acute manic episodes in bipolar I disorder, as monotherapy; and in adolescents (13-17 years) for schizophrenia. Patients should be periodically reassessed to determine the need for treatment and the appropriate dose. Seroquel XR® is not approved for use in pediatric patients under ten years of age. The most commonly observed adverse reactions in clinical trials for children and adolescents were somnolence, dizziness, fatigue, increased appetite, nausea, vomiting, dry mouth, tachycardia, and weight gain. Other adverse reactions include increased risk of suicidal thought and behavior in children, Neuroleptic Malignant Syndrome, metabolic changes, hyperglycemia and diabetes mellitus, dyslipidemia, tardive dyskinesia, hypotension, falls, increases in blood pressure in children and adolescents, leukopenia, neutropenia, and agranulocytosis. Quetiapine is a dangerous drug within the meaning of Business and Professions Code section 4022.

15. Lithium carbonate is not indicated for the treatment of conditions other than manic episodes of Bipolar Disorder, and Manic Depressive illness. It is indicated as a maintenance treatment for individuals with a diagnosis of Bipolar Disorder in order to reduce the frequency of manic episodes and diminish the intensity of those episodes which may occur. Lithium toxicity is closely related to serum lithium levels, and can occur at doses close to therapeutic levels. Lithium carbonate is a dangerous drug within the meaning of Business and Professions Code section 4022.

16. Divalproex sodium (Depakote®) is an anticonvulsant used to treat seizure disorders, manic episodes associated with bipolar disorder, and to prevent migraine headaches in adults and children 10 years of age and older. Depakote® is not indicated for treatment of conditions other than seizure disorders, manic episodes associated with bipolar disorder, and migraine headache prevention. Side effects can be serious and sometimes fatal, including continuing liver damage despite stopping taking the drug. Fatal liver damage is especially likely in children younger than

two years old. Other side effects include, but are not limited to, fatal pancreatic inflammation, suicidal thoughts or actions, bleeding problems, high ammonia blood levels, low body temperature, allergic reactions, drowsiness or sleepiness. Depakote is a dangerous drug within the meaning of Business and Professions Code section 4022.

17. Acetaminophen and codeine (Tylenol® with codeine, Tylenol 3®) is a combination of two medicines used to treat moderate to severe pain. Codeine is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of codeine. Codeine has a high potential for abuse. Codeine is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations.

18. Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

19. Alprazolam (Xanax®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for

the short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

21. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration ("DEA") has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 41.) Respiratory depression is the chief hazard from all opioid agonist preparations.

22. Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated phentermine HCL is used as a short term adjunct in a regiment of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

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FACTUAL ALLEGATIONS

23. ***PATIENT A***[2]

a) In 2015, Patient A had sole custody of her 7-year-old daughter (Patient B), after being widowed. In approximately 2015, Patient A married Respondent. Respondent and Patient A conceived a son by frozen embryo transplantation who was born in February of 2017.

b) According to Respondent's medical billing records, Patient A saw Respondent for medical treatment while she was pregnant on or about January 17, 2017; February 10, 2017; and February 16, 2017 (the day their son was born). However, there are no medical records from Respondent showing any treatment on these dates.

c) On February 23, 2017, one week after Patient A's C-section delivery, Respondent treated her for an incisional hernia and referred her to a surgeon.

d) On or about April 13, 2017, Patient A was seen by Respondent for a complete annual exam, including a breast and pelvic exam. She was noted to have edema from her recent pregnancy and delivery, and was given Pitocin IM and Reglan. This is the first and only annual exam noted in Respondent's medical records.

e) On or about September 5, 2017, Respondent treated Patient A for a rash and a history of allergies.

f) Patient A filled the following prescriptions for controlled substances, issued by Respondent:

Date	Prescription	Dose	Quantity	Days Supply
11-17-2015	Acetaminophen-Codeine Phosphate	300 mg/ 60 mg	100	17
2-25-2016	Zolpidem Tartrate	10 mg	30	30
4-14-2016	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	60	7
5-4-2016	Alprazolam	2 mg	90	30
6-2-2016	Zolpidem Tartrate	10 mg	30	30
6-13-2016	Diazepam	10 mg	90	30

[2] Patients are referred to by letter to preserve their privacy.

7-24-2016	Zolpidem Tartrate	10 mg	30	30
10-11-2016	Alprazolam	2 mg	90	30
12-7-2016	Zolpidem Tartrate	10 mg	90	90
12-7-2016	Diazepam	10 mg	90	30
2-18-2017	Oxycodone HCL – Acetaminophen	325 mg/ 5 mg	60	15
3-1-2017	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	120	30
5-1-2017	Phentermine HCL	37.5 mg	90	90
8-7-2017	Diazepam	10 mg	90	30

g) In addition, Respondent prescribed 30 mg of Adderall® daily to Patient A on or about the following dates: December 10, 2015; August 5, 2016; September 22, 2016; October 5, 2016; November 12, 2016; December 11, 2016; January 6, 2017; February 23, 2017; and March 29, 2017. Respondent also prescribed 37.5 mg of phentermine (quantity 90) to Patient A on or about May 1, 2017, approximately three months after she gave birth to their son.

h) Based on Respondent's November 17, 2015 prescription of codeine phosphate, Patient A was taking approximately 320 to 480 mg of codeine per day.

i) None of Respondent's medical records for Patient A mention the prescriptions listed above. There are no medical records, exams, or definitive diagnoses made related to Patient A's prescriptions. Respondent's medical records fail to provide any documentation of informed consent, discussion of side effects or alternatives, pain contracts, drug testing, or plans to taper.

j) During his interview with Board Investigators, Respondent disputed Patient A's April 14, 2016 prescription for oxycodone, which stated she was to take 60 pills over the course of 7 days, equating to 8 to 9 pills of 325 mg/ 10 mg of oxycodone per day. Respondent stated that he did not know where the seven days came from in the prescription or how the pharmacist came up with that number.

k) It is the standard of care when prescribing controlled substances to provide clear documentation in the medical record of the performance of a history and physical, along with careful diagnosis and planned management, specialist consultation as needed, obtain informed consent (e.g., pain contract), include tapering plans, consider drug testing, look for adverse side effects, and look for abuse or diversion of medications.

l) Respondent failed to properly prescribe controlled substances to Patient A. Respondent regularly prescribed significant amounts of opiates and benzodiazepines and failed to document any diagnosis in Patient A's medical records. The only diagnoses are inferred from his written prescriptions which state Adderall® is for "ADD," diazepam is for "muscle spasm and stress headaches," and oxycodone is for "severe surgery site pain." The most complete note from the only annual examination on or about April 13, 2017, contains no notations or explanations of his prescriptions of high dose prescriptions of oxycodone. In addition, there is no notation or explanation in Respondent's medical records regarding the reason for prescribing phentermine to Patient A on or about May 1, 2017.

m) It is the standard of care to avoid prescribing opiates and benzodiazepines in combination, due to the increased risk of synergistic effects of sedation, possibility of overdose, respiratory depression, and death. The combination of zolpidem and oxycodone is in the serious interaction category which calls for using an alternative rather than prescribing both consecutively. This is due to the high risk of profound sedation, respiratory depression, coma, and hypotension. Oxycodone and alprazolam require close monitoring because they both increase sedation. In addition, a physician cannot reasonably be dispassionately objective in prescribing controlled substances to a spouse as multiple factors will sway his clinical judgement, such as pleasing his spouse or subconsciously denying the possibility of serious issues in said spouse.

n) Respondent issued numerous prescriptions of opiates and benzodiazepines in combination to Patient A. For example, on or about December 7, 2016, Respondent prescribed Patient A with 10 mg of zolpidem daily and 30 mg of diazepam daily; such a combination may

cause additive central nervous system depression. On or about April 14, 2016, Respondent prescribed Patient A with 10 mg of oxycodone daily. Two weeks and four days later, on or about May 4, 2016, Respondent additionally prescribed Patient A with 30 mg of zolpidem daily. Then, on or about June 2, 2016, Respondent increased Patient A's zolpidem dosage to 10 mg daily and again increased, on or about June 13, 2016, to 30 mg daily. Moreover, on or about December 7, 2016, Respondent prescribed Patient A with 10 mg of zolpidem daily for three months. Approximately two months later, on February 18, 2017, Respondent prescribed Patient A with 10 mg (4-6 pills daily) of oxycodone. Approximately 14 days later, on March 1, 2017, Respondent increased her oxycodone dosage prescribing 120 pills. The dosage of 40 mg of oxycodone daily equates to approximately a morphine equivalent dose of 60 mg daily, which is considered an addictive level with a high risk of overdose and abuse.

o) On or about January 8, 2020, during an interview with Board Investigators, Respondent stated under oath that Patient A's fertility physician "asked me if I would follow [Patient A] and provide for her medications in Oakdale so she wouldn't have to drive each time over to Palo Alto to see him." When asked if the treating fertility physician asked Respondent to write prescriptions for minivelle, progesterone, and letrozole, Respondent stated, "Yes sir, that's correct. Exclusively." However, Patient A's fertility physician informed Board Investigators that he "never allowed, consented, consulted nor directed [Respondent] to prescribe, continue to prescribe, nor treat [Patient A] on his behalf as a physician. He did not supervise nor allow [Respondent] to continue to prescribe drugs related to fertilization." In addition, Patient A's medical records had no evidence that Respondent was directed by a specialist physician to administer progesterone injections or other fertility treatments.

24. ***PATIENT B***

a) At approximately the age of seven, Patient B became Respondent's stepdaughter after her mother married him in the summer of 2015. Respondent gave Patient B a diamond ring,

similar to an engagement ring, and she wore it on her ring finger. Respondent told Patient A that it was a sentimental gift between a father and a daughter.

b) At the age of three, Patient B and/or her biological parents saw an LCSW counselor twice over concerns that Patient B suffered from ADHD[3]. Patient B's biological parents were not interested in medications, and Patient B seemed better at her preschool by the second visit.

c) Respondent's medical records for Patient B comprise of only one visit on or about October 17, 2016. According to Respondent's notes Patient B's history showed a "diagnosis of ADHD at [] hospital at age of two." Respondent's medical records state Patient B was already prescribed 30 mg of Adderall®, taking half a tablet twice daily. However, there are no medical records to support this, and Respondent initiated ADHD therapy on his own. Respondent noted that Patient B's immunization history was "none." However, Patient B's prior medical records show many immunizations from birth to 2013. Respondent's exam notations were normal and his assessment was, "well child, ADHD, sick building syndrome and chronic sinus/allergic rhinitis." Respondent never ordered any laboratory testing or EKG's. Respondent's noted plan was to continue current medications at present dosages.

d) Patient B obtained the following controlled substances based on prescriptions issued by Respondent:

Date	Prescription	Dose	Quantity	Days Supply
12-10-2015	Mixed Amphetamine Salts	15 mg	8	8
12-29-2015	Mixed Amphetamine Salts	15 mg	30	30
2-2-2016	Mixed Amphetamine Salts	15 mg	30	30
3-1-2016	Amphetamine Salt Combo	30 mg	30	30

[3] Attention deficit hyperactivity disorder (ADHD) is a mental health disorder that can cause above-normal levels of hyperactive and impulsive behaviors. People with ADHD may also have trouble focusing their attention on a single task or sitting still for long periods of time.

Date	Prescription	Dose	Quantity	Days Supply
4-2-2016	Amphetamine Salt Combo	30 mg	30	30
5-4-2016	Amphetamine Salt Combo	30 mg	30	30
6-13-2016	Mixed Amphetamine Salts	30 mg	30	30
7-6-2016	Amphetamine Salt Combo	30 mg	30	30
8-6-2016	Amphetamine Salt Combo	30 mg	30	30
9-12-2016	Amphetamine Salt Combo	30 mg	30	30
10-11-2016	Amphetamine Salt Combo	30 mg	30	30
11-12-2016	Amphetamine Salt Combo	30 mg	30	30
12-12-2016	Amphetamine Salt Combo	30 mg	30	30
1-10-2017	Amphetamine Salt Combo	30 mg	30	30
2-23-2017	Amphetamine Salt Combo	30 mg	30	30
3-29-2017	Amphetamine Salt Combo	30 mg	30	30
5-1-2017	Mixed Amphetamine Salts	30 mg	30	30
5-9-2017	Amphetamine Salt Combo	30 mg	30	30
6-7-2017	Amphetamine Salt Combo	30 mg	30	30
7-2-2017	Amphetamine Salt Combo	30 mg	60	30
7-28-2017	Dextroamph Sacc-Amph ASP-Dextroam S	30 mg	30	30

e) According to Respondent's medical records, he began prescribing Patient B with 20 mg of Adderall® for ADHD on or about August 28, 2015. The starting dose for Adderall® is typically 5-10 mg. Respondent continued Patient B's Adderall® prescriptions monthly through approximately July of 2017.

f) Respondent's first record of an office visit for Patient B occurred on or about October 17, 2016, over one year after he began prescribing psychotropic medications for her. Respondent failed to obtain a baseline EKG, which most pediatricians would obtain to

monitor the slight risk of cardiomyopathy. Respondent failed to perform any laboratory work on Patient B. Laboratory monitoring is necessary, as dosage modification is required based on toxicity and possible issues. Respondent failed to order any confirmatory tests (e.g., Conner Scale[4]), or provide a referral for confirmatory tests that Patient B in fact had ADHD or bipolar disorder.

g) The following day, on or about October 18, 2016, Patient B was seen by a psychiatrist at a children's health medical practice. Respondent and Patient A accompanied her. The history provided was that Patient B was a sweet, social, and hyperactive child, up to the age of seven. After Patient B witnessed domestic abuse between her biological father and mother in approximately 2014, Patient B stopped talking for several months and would only sing and stutter. Patient B then saw a counselor and made significant progress. However, in approximately 2015, Patient B's father committed suicide and her mother (Patient A) married Respondent. When Patient A was approximately five to six months pregnant, Patient B regressed at home and the overall impression was post-traumatic stress disorder (PTSD), with Respondent "managing her medications in their rural community." In addition, Patient B was noted to experience symptoms consistent with Dysphoric Mood Dysregulation Disorder except that they only occurred around Respondent and Patient A, which led more towards symptoms of Oppositional Defiant Disorder with an unspecified Bipolar Disorder. Further counseling was recommended and the psychiatrist noted that Patient B's "emotional, social and family functioning are at high risk for further medical and psychological complications and progression." It was recommended that Adderall® dose reduction be considered based on patient irritability. The psychiatrist recommended quetiapine (Seroqual®) 25 mg at bedtime titrating by 25 mg weekly to a maximum dose of 100 mg nightly. During an interview with Board Investigators, the psychiatrist stated the Respondent initiated the referral and Respondent "did most of the talking at the visit."

[4] The Conners Comprehensive Behavior Rating Scale (CBRS) is a tool used to gain a better understanding of academic, behavioral and social issues that are seen in young children between ages six to eighteen years old. It is frequently used to assist in the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

The psychiatrist advised that Patient B's medications were to be managed by a trained psychiatrist, stating it was beyond the scope of a primary care physician to manage psychotropic medications for a child. The psychiatrist referred Patient B to a physician in Modesto, and provided Respondent with names for therapists. Subsequently, Patient B's referral appointment with the Modesto physician was canceled and Patient B was thereafter never seen, nor was her medication managed by a trained psychiatrist.

h) That same day, on or about October 18, 2016, Respondent (a primary care physician and not a trained psychiatrist) began managing Patient B's psychotropic medications. Respondent prescribed Patient B quetiapine (Seroqual®) 25 mg, quantity of 120, equating to possibly 1-4 per day, and 25 to 100 mg daily. On or about October 25, 2016, Respondent increased Patient B's dosage of quetiapine to 100 mg daily, with a quantity of 30. Respondent noted that Patient B had an excellent response to quetiapine and suffered from "anxiety/panic/agitation." On or about November 25, 2016, Respondent again increased Patient B's dosage to 200 mg per day, by increasing the dosage quantity to 60. On or about January 6, 2017; February 1, 2017; and March 29, 2017, Respondent continued to prescribe Patient B with 200 mg of quetiapine daily. The psychiatrist who saw Patient B on or about October 18, 2016, had recommended a maximum dosage of 100 mg of quetiapine daily. However, Respondent eventually prescribed Patient B with 400 mg of quetiapine daily. The safety and efficacy of quetiapine is not established prior to the age of ten. Side effects of quetiapine include dizziness, fatigue, blood pressure elevation, lipid elevation, dry mouth, headache and somnolence, QT interval prolongation, and risk of extrapyramidal (Parkinsonian) side effects. Respondent made no chart notes regarding these prescriptions, made no diagnoses, and failed to follow the recommendations of the psychiatrist.

i) In addition, on or about March 1, 2016, Respondent added more psychotropic medications and prescribed Patient B with 300 mg of lithium, two to three times per day. Patient B was eight-years-old at the time. Respondent began prescribing her lithium without having any diagnosis for bipolar disorder from specialists. Lithium causes significant side

effects, including an elevated white cell count, polyuria and polydipsia, dry mouth, hand tremors, confusion, memory issues, headaches, weakness, gastrointestinal symptoms, and EKG changes. Careful monitoring is necessary, especially with blood levels to avoid toxicity, along with kidney and thyroid tests; Respondent failed to perform any of these tests. The lithium prescription was concurrent with the Adderall® prescription, which was increased to 30 mg, on or about March 1, 2016. Of note, lithium combined with Adderall® can cause a serotonin syndrome or increased agitation and high fever. On or about June 13, 2016, Respondent again currently prescribed Patient B 300 mg of lithium and 30 mg of Adderall®.

j) On or about June 2, 2016, Respondent added more psychotropic mediations and prescribed Patient B 500 mg of Depakote twice daily, with a quantity of 60. Depakote is not recommended for children under the age of ten, due to serious side effects, including but not limited to, permanent liver damage, life-threatening pancreatitis, suicidal thought, and blood and metabolic disorders. Patient B was eight at the time.

k) In prescribing of all of these psychotropic agents to Patient B, Respondent made no chart notes discussing any of these medications, except one mention that Patient B was already taking Adderall® during the one office visit on or about October 17, 2016. Respondent failed to make any diagnoses regarding Patient B. Respondent failed to follow the recommendations of the psychiatrist, and against her recommendation, he began solely managing Patient B's psychotropic prescriptions despite such management being beyond the scope of his practice. The psychiatrist recommended quetiapine with a maximum dose of 100 mg daily; instead, Respondent increased Patient B's dosage up to 400 mg daily and added additional psychotropic medications (Lithium and Depakote). Respondent failed to properly monitor Patient B while she was taking the numerous medications he prescribed. Respondent's prescribing of numerous psychotropic medications to Patient B was an extreme departure from the standard of care and caused definite harm to Patient B both physically and psychologically.

l) During his interview with Board investigators, Respondent claimed that he did not know what occurred during the meeting with the psychiatrist because he spent the whole time outside playing with Patient B, while the mother (Patient A) spoke with the psychiatrist. Nonetheless, Respondent told Board investigators that he provided the Seroquel prescription based upon the recommendations of the psychiatrist, and the psychiatrist herself told Board investigators that Respondent had done "most of the talking" during the visit.

m) On or about August 20, 2017, Patient A and Respondent separated.

n) On or about September 12, 2017, Patient B told her mother (Patient A) that she wished she could have locked her bedroom door at Respondent's home. When Patient A asked why, Patient B responded that Respondent would not let her use the bathroom when he slept in her bed and that Respondent slept in her bed with her wearing only his underwear. Patient B went on to explain that Respondent would put his hands together and, "get comfortable." When asked what "getting comfortable" meant, Patient B put both of her hands together in a praying motion, laid down on her back, placed her clasped hands in her genital area and started "gyrating" her body up and down while shifting her head left to right. Patient B also reported this to her nanny/house cleaner.

o) On or about September 14, 2017, Patient A drove Patient B to Child Protective Services (CPS) in Modesto and told Patient B that she needed to tell them what happened. Patient B responded, "I don't want to tell them that, I don't trust you." Against her will, Patient B was escorted by Patient A into CPS in order to file a report. Patient B was interviewed by a CPS staff member, and when asked about her private parts, she refused to name them. When Patient B was asked about her private parts, she immediately stated "her stepdad [Respondent] did not do any of those things." When questioned about what "those things meant," Patient B stated that Respondent would not sleep in the king-sized bed with her mother. Instead, he slept in her bed with her for two hours each night. She denied that anyone had ever touched her "private parts or made her feel uncomfortable." She reported that if someone did, she would tell her mother. The CPS staff member concluded the

interview and returned Patient B to her mother (Patient A). After they left CPS, Patient A and Patient B returned and requested that CPS re-interview Patient B. The CPS staff refused, "not being sure what the mother had discussed with [Patient A] and then coming back." The CPS staff member stated another employee would follow-up with them.

p) On or about September 18, 2017, another CPS employee interviewed Patient B at her school. Patient B stated that she was frightened, but the CPS employee calmed her fears and told her that she was not in trouble, but that he would like to ask her some questions. Patient B told CPS that Respondent liked to sleep in her bedroom, and he does not like sleeping with her mother (Patient A). Patient B stated that Respondent has never touched her inappropriately; however, she has seen him many times while sleeping put his hands in a "prayer way" between his legs and would be shaking. Patient B demonstrated what was described as convulsing. Patient B stated that she was always scared when Respondent put his hands between his legs. Patient B stated that she was able to see Respondent's hands because the night light was always on.

q) On or about September 23, 2017, an Oakdale Police Officer responded to Patient A's report of Respondent's alleged lewd and lascivious acts with a child. The officer asked Patient A why Respondent slept in Patient B's bed and Patient A responded that during the past two years that she had been married to Respondent, they had only had sexual intercourse approximately 12 times.

r) On or about October 5, 2017, an Oakdale Police Department detective interviewed Patient A. She reported that Respondent took a special interest in Patient B and chose to sleep in her bedroom at night. Patient B began wetting herself and defecating in her pants. Respondent and Patient A's relationship became strained over their two-year marriage and Respondent showed no interest in being intimate with Patient A. After Respondent moved out of the home, Patient B told her about Respondent "convulsing" at night in her bed with his hands between his legs.

s) On or about October 11, 2017, the Stanislaus Family Justice Center conducted a recorded interview with Patient B, who was nine-years-old at the time. Patient B stated that she

was "really thinking that [Respondent] was going to be a good dad," but when she was approximately seven-years-old, Respondent began coming into her bedroom at bedtime and closed the door behind him. Respondent had Patient B recite the prayer, "Now I lay me down to sleep," take off his clothes (leaving on his underpants), and then would sit in the bed with his hands in his underpants, touching his "private parts." Patient B described that Respondent would move and make "convulsing" motions, and he would moan loudly. Patient B stated that Respondent would not allow her to get out of bed and sometimes would place his hand on her shoulder or stomach. Patient B stated that Respondent did this several times throughout the night, sometimes waking her. When asked how many times this occurred, Patient B replied, "730." When asked if she was scared, Patient B responded that Respondent was 6 foot 4 inches tall and asked the interviewer to put herself in Patient B's place. Patient B stated that her mother (Patient A) was tired and sick during that time because she was pregnant with her baby brother.

t) On October 19, 2017, Patient A made a pre-text call to Respondent with police officers on the line with her. Patient A stated, "I guess I know why you'd never sleep in the same room as me, how could you do this?" Respondent replied by saying something about a housewife show and a referral he may have to give. It appeared to the officer that Respondent did not know whom he was speaking with. Patient A stated, "What are you talking about?" Based on Respondent's tone, the officer thought Respondent seemed to know that authorities were listening to the call. Respondent stated, "Goodbye," and hung up the phone. The next day Respondent provided the officer a typed letter detailing the pre-text phone call; however, Respondent claimed in his letter that he made statements that he did not in fact make during the recorded call.

u) On February 9, 2018, Patient A took Patient B to a children's hospital. Patient B disclosed that Respondent masturbated next to her. Patient B also disclosed that Respondent would lay behind her, hold her down, and stick his penis in her anus. Then, he would tell her to stay in bed and he would take a shower.

v) On February 20, 2018, when Patient B was approximately nine years old, she was again interviewed. Patient B stated that when they moved in with Respondent he started coming into her bedroom on her first night there. Patient B reiterated that Respondent would make her say the prayer, "Now I lay me down to sleep," and then Respondent would climb into bed with her and "touch his private parts" inside his underwear. She could see him holding his "private parts in his hand" and move while making a "strange moaning noise." Patient B described the movement. Sometimes Respondent would put his hand on her stomach. Respondent would stop after approximately 15 minutes and then fall asleep in her bed. Patient B stated that Respondent did the same thing the next night and "he did more the next time." Patient B described that Respondent came into her room and closed the door, and had her pray with him, and then he made her climb into her bed with him. Respondent "grabbed" Patient B "super fast" and "put [her] on [her] side." He pulled down her pajamas and underwear, Patient B stated that she "tried to get out of there," but Respondent "wouldn't let go of [her.]" Respondent did not say a word. Respondent had a "clear bottle" with clear liquid, and he would put some of it in his hands and rub it "all over" his "private parts." Then, Respondent "put his private parts inside [her] bum." Patient B said it hurt so bad that she felt like she was going to faint. She also felt like she was "going to scream," but she was "so scared that [she] couldn't even scream." Respondent got out of bed and raised his voice, telling Patient B to "stay in bed," and he went to take a shower in her bathroom. Patient B obeyed because she was "too scared to move." Patient B felt sticky and uncomfortable after Respondent put his "private part inside her bum." After Respondent finished showering, he got back into bed with Patient B, and touched his private parts with both hands again, while moaning and moving. Then, Respondent would face away from Patient B and fall asleep. Respondent took showers only after he put his "private part inside of [her] bum." Patient B stated that in the morning, she would find, "little brown particles" in her shower; she cleaned it up with a wet cloth. Patient B explained that Respondent would "only put his private parts inside of [her] bum, like every other night, but he never skipped a night touching his

private parts." Patient B stated that her "bum hurt" in the mornings and she would have "accidents" in her pants. Patient B "couldn't wipe" and when she did, there was "blood on the toilet paper." Patient B clarified that she thinks Respondent's private part is "called a penis."

w) On July 2, 2020, Board Investigators interviewed 11-year-old Patient B. Patient B felt that after Respondent married her mother, he "was going to be good because he was nice and he was a doctor." Respondent gave Patient B a ring and put it on her ring finger. Patient B described that every other night, Respondent would come into her bedroom at night and make her pray with him. She saw him undress down to his underwear and get into her bed, lying next to her. Respondent put both of his hands together and put them in his underwear in his pubic area. She saw him move his hands up and down in short rubs and could feel his body move. Patient B was "frozen" and "felt paralyzed from fear," until she eventually fell asleep. Patient B stated that it lasted for a while, but could not specify a specific amount of time. This occurred for the first time when Patient B was approximately seven years old. On alternate nights, when Respondent did not place his hands in his groin area while in bed with her, Patient B stated Respondent would climb into her bed and make her "bum" or anus hurt. After a while, Respondent stopped and Patient B would be in pain. Respondent would typically get up from her bed and take a shower in her attached bathroom at the "big house," or a bath in the kitchen bathroom in the "little house." Patient B would eventually fall asleep. When she woke up in the morning, Respondent would be gone. Her "bum" would still hurt in the morning and she would be in pain throughout the day and have uncontrollable "accidents," where she defecated in her underwear. Patient B would then hide her underwear. She only experienced "accidents" on nights that Respondent made her "bum" hurt. Respondent would alternate his behavior, one night touching himself and the next night making her "bum" hurt. Patient B only recalled two times when Respondent did not climb into bed with her. It was during the summer when she was eight, and they stayed in two adjacent cabins by the lake; Respondent and her mother stayed in one cabin and Patient B and her

nanny stayed in the other cabin. When they moved back to "the little house," after the summer, Patient B recalled that she slept on an inflatable mattress in the playroom or on the futon in the living room. Patient B told her mother about what Respondent had been doing to her after a couple of weeks had passed and she was confident that Respondent was not returning to her home.

FIRST CAUSE FOR DISCIPLINE

(Sexual Exploitation)

25. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under sections 2246 and 729, in that Respondent is guilty of sexual exploitation of Patient B. The facts and circumstances are alleged in paragraph 23 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Sexual Misconduct)

26. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 726, in that Respondent committed acts of sexual abuse and misconduct with Patient B. The facts and circumstances are alleged in paragraph 23 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

27. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (b) in that Respondent was grossly negligent in his care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 22 and 23 which are hereby incorporated by reference and realleged as if fully set forth herein.

a) Regarding Patient A, Respondent was grossly negligent in his care and treatment of her, including but not limited to: failing to document any history, physical examination, diagnosis, or treatment plan related to his prescribing of multiple controlled substances; failing to discuss side effects or alternatives; failing to make specialist consultations and/or referrals; failing to obtain informed consent; failing

to create and maintain a pain contract; failing to include tapering plans; failing to consider and utilize drug testing; failing to follow-up and look for adverse side effects; failing to ensure proper use of the medications; failing to discuss the long period of Adderall® use in his notations; and failing to note and/or explain the high doses of oxycodone he prescribed.

b) Regarding Patient B, Respondent was grossly negligent in his care and treatment of her, including but not limited to: prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist by prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist in the dosage of psychotropic medications; failing to obtain a baseline EKG; failing to request laboratory blood work in order to monitor psychotropic medication dosages and possible toxicity; kidney issues, and thyroid issues; failing to request or administer confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium and Adderall® concurrently; prescribing Depakote when she was seven, which is not recommended to children under the age of ten; prescribing Seroquel when she was seven, which is not recommended to children under the age of ten; increasing the Seroquel dosage from the recommended maximum of 100 mg daily up to 400 mg daily; failing to chart any notes of the psychotropic medications beyond the one note on October 17, 2016 regarding Adderall®; failing to substantiate any diagnoses; failing to properly monitor her on her medications; prescribing medication to Patient B while she was his step-daughter, when he could not be properly objective; and causing physical and psychological harm to Patient B.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

28. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 22 and 23 which are hereby incorporated by reference and realleged as if fully set forth herein.

a) Regarding Patient A, Respondent committed repeated negligent acts, including but not limited to: prescribing opiates and benzodiazepines in combination which is a serious interaction, thereby increasing the risk of synergistic effects of sedation, with the possibility of overdose, respiratory depression and death; prescribing opiates and benzodiazepines while psychiatrists concurrently prescribe alprazolam and amphetamines; prescribing a morphine equivalent does of 60 mg daily, which is an addictive level with a high risk of overdose and abuse; failing to document any history, physical examination, diagnosis, or treatment plan related to his prescribing of multiple controlled substances; failing to discuss side effects or alternatives; failing to make specialist consultations and/or referrals; failing to obtain informed consent; failing to create and maintain a pain contract; failing to include tapering plans; failing to consider and utilize drug testing; failing to follow-up and look for adverse side effects; failing to ensure proper use of the medications; failing to discuss the long period of Adderall® use in his notations; and failing to note and/or explain the high doses of oxycodone he prescribed; and prescribing sedatives to his spouse, when a physician cannot reasonably be dispassionately objective.

c) Regarding Patient B, Respondent was grossly negligent in his care and treatment of her, including but not limited to: prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist by prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist in the dosage of psychotropic medications; failing to obtain a baseline EKG; failing to request laboratory blood work in order to monitor psychotropic medication dosages and possible toxicity; kidney issues, and thyroid issues; failing to request or administer confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium and Adderall® concurrently; prescribing Depakote when she was seven, which is not recommended to children under the age of ten; prescribing Seroquel when she was seven, which is not recommended to children under the age of ten; increasing the Seroquel dosage from the recommended maximum of 100 mg daily up to 400

mg daily; failing to chart any notes of the psychotropic medications beyond the one note on October 17, 2016 regarding Adderall®; failing to substantiate any diagnoses; failing to properly monitor her on her medications; prescribing medication to Patient B while she was his step-daughter, when he could not be properly objective; and causing physical and psychological harm to Patient B.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty)

29. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (e), in that Respondent committed an act or acts involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon. The facts and circumstances are alleged in paragraph 22 and are incorporated by reference as if fully set forth. Additional circumstances are as follows:

30. On or about January 8, 2020, Respondent stated under oath to Board Investigators that Patient A's fertility physician "asked me if I would follow [Patient A] and provide for her medications in Oakdale so she wouldn't have to drive each time over to Palo Alto to see him." Respondent clarified that Patient A's fertility physician asked Respondent to write prescriptions for minivelle, progesterone, and letrozole. Patient A's fertility physician informed Board Investigators that he never allowed, consented, consulted, nor directed Respondent to prescribe, continue to prescribe, nor treat Patient A on his behalf as a physician.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60965, issued to Mark Daniel Cook, M.D.;

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

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3. Ordering Mark Daniel Cook, M.D., to pay the Board the costs of the investigation and enforcement of this case incurred beginning on January 1, 2022, and if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: DEC 09 2022

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

Exhibit B

Accusation No. 800-2020-072482

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

In the Matter of the Accusation Against: **Mark Daniel Cook, M.D.** **1425 West H St. Ste. 200** **Oakdale, CA 95361** **Physician's and Surgeon's Certificate No. A 60965,** Respondent.	Case No. 800-2020-072482 **ACCUSATION**

PARTIES

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

2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> (f) Approving undergraduate and graduate medical education programs.
>
> (g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).
>
> (h) Issuing licenses and certificates under the board's jurisdiction.
>
> (i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:
>
> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.
>
> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

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

6. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet website, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet website.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

STATUTORY PROVISIONS

7. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the

licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

PERTINENT DRUGS AND DEFINITIONS

10. Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

11. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

12. Clonidine® lowers blood pressure by decreasing the levels of certain chemicals in your blood. This allows your blood vessels to relax and your heart to beat more slowly and easily. It is used to treat hypertension (high blood pressure). Clonidine is a dangerous drug within the meaning of Business and Professions Code section 4022.

13. Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

14. Gabapentin (Neurontin®, Gralise®, Horizant®) is a medicine used to treat partial seizures, nerve pain from shingles, and restless leg syndrome. It works on the chemical messengers in your brain and nerves. Gabapentin is a dangerous drug within the meaning of Business and Professions Code section 4022.

15. Hydroxyzine reduces activity in the central nervous system. It is used as a sedative to treat anxiety and tension. Hydroxyzine is a dangerous drug within the meaning of Business and Professions Code section 4022.

16. Lisinopril® is an angiotensin-converting enzyme (ACE) inhibitor used to treat high blood pressure in adults and children who are at least six years old. Lisinopril is a dangerous drug within the meaning of Business and Professions Code section 4022.

17. Modafinil (Provigil®) is a central nervous system stimulant that promotes wakefulness. Central nervous system stimulants are medicines that stimulate the brain, speeding up both mental and physical processes. Modafinil is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to

Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat excessive sleepiness caused by sleep apnea, narcolepsy, or shift work sleep disorder.

18. Oxycodone (Oxaydo®, OxyContin®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline power derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. When properly prescribed and indicated, oxycodone is used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. Respiratory depression is the chief hazard from all opioid agonist preparations. The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.)

19. Seroquel® (quetiapine) is an antipsychotic medicine that changes the chemical actions in the brain. It is used to treat schizophrenia, bipolar disorder, and in combination with antidepressant medications ,it is used to treat major depressive disorder in adults. Seroquel is a dangerous drug within the meaning of Business and Professions Code section 4022.

20. Trazodone (Desyrel®, Desyrel Dividose®, Oleptro®) is an antidepressant that belongs to a group of drugs called serotonin receptor antagonists and reuptake inhibitors (SARIs). It is used to treat major depressive disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

21. Vyvanse® (lisdexamfetamine) is a central nervous system stimulant that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is used to treat attention deficit hyperactivity disorder (ADHD) in adults and in children who are at least 6 years old. Vyvanse® may be habit-forming, and it is a drug of abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

22. Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

23. Zolpidem tartrate (Ambien®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used to treat insomnia and has potential for abuse.

FACTUAL ALLEGATIONS

2020

24. On or about September 22, 2020, at approximately 2139 hours, Sheriff's deputies arrived at Respondent and Patient C[1]'s shared residence due to a domestic dispute. Patient C stated that she needed help moving out of the house because she did not feel safe leaving without assistance from the police. She stated that she married Respondent in Mexico, but they were not

[1] Patient names are redacted to protect their privacy. Allegations related to Patient A and B are currently pending in Accusation No. 800-2017-039585.

legally married in the United States. Patient C told the deputies that there was a history of domestic violence between the two of them, and that Respondent had assaulted her with a wooden paddle. Shortly thereafter, Patient C stated that no physical altercation had occurred. Patient C stated that she was concerned about not taking her medication that Respondent was prescribing to her, and that it would make everything better. When asked what medication she was taking, Patient C only identified her blood pressure medication. Later the same night, Patient C called the police several times stating that the incident was a misunderstanding and that she wanted the police to delete the report against Respondent.

25. On or about September 28, 2020, at approximately 0428 hours, officers responded to the home of Respondent and Patient C. Respondent called 911 to report that his wife, Patient C, was naked and had punched him during an argument. Dispatchers noted that they could hear Patient C screaming in the background that Respondent dragged her outside by her hair. Respondent was wearing medical scrubs when the police interviewed him. He stated that he was sleeping on the couch when he awoke to Patient C yelling at him about red ants being in the house. He assured her that there were no red ants, and that if there were, it was due to her children visiting them the week prior. Respondent stated that he tried to go back to sleep, but Patient C hit him near his lower left jaw. Patient C continued to yell at him about their relationship, and he grabbed her by the arms and shoulders and forced her outside of their residence for fear that she would continue to assault him. Respondent said he suffered no injuries and was only experiencing minor pain. He told the officers that when he grabbed Patient C's shoulders he may have accidentally grabbed her hair while removing her from the residence. Respondent denied ingesting any drugs or alcohol, and would not provide the police officers any further information regarding Patient C's state of mind or use of substances. Respondent chose not to press charges, but did request an emergency protection order. He told officers that he had a 15-minute audio recording of Patient C yelling at him and played some of the recording for officers. Officers noted that Respondent could be heard on the recording saying that Patient C raped him, but Respondent denied this and said that it was childish. Patient C admitted to the officers that she had consumed alcohol, valium, clonazepam, marijuana, smoked cigarettes,

admitted to slapping Respondent, and that she took any kinds of pills or narcotics she could find. Patient C told officers that she slapped him because he did not love her anymore and wanted a divorce. She added that she had made a false report to the police in the week prior as well. Patient C was arrested and served with an emergency protective order requiring her to stay away from Respondent. Respondent was provided with his own copy of the emergency protective order by officers. During transport to the jail, Patient C began to tell officers that she had bruises on her body from a previous assault by Respondent, but quickly changed her mind and did not want to tell them anything further. Patient C refused to allow the officers to take pictures of her injuries.

26. On or about September 28, 2020, at approximately 2010 hours, the same day as the prior call, police responded to the home shared by Respondent and Patient C due to report of a suicidal female. Respondent reported that he witnessed his wife, Patient C, ingest twenty to thirty blood pressure pills while talking about wanting to die. Patient C appeared agitated, slurred her speech, and found it difficult to focus and engage in her conversation with paramedics. Patient C denied depression, suicidal ideation or taking any medication, adding that Respondent was a liar. Respondent told officers that during an argument, Patient C ingested approximately 20-30 tablets of blood pressure medication without warning. Respondent stated that as a medical doctor, he recognized that the amount of Clonidine could be fatal without treatment and called for emergency services immediately. Respondent added that Patient C has no current specific psychiatric or mental health diagnoses, and that their marriage has been experiencing difficulty. Patient C was taken to the hospital pursuant to 5150 psychiatric hold based on Respondent's observations that she had taken the Clonidine pills.

27. On or about August 5, 2020, Patient C presented to Respondent for her first documented visit to establish care. The history stated that Patient C suffered from "severe chronic ADHD, insomnia, anxiety and grief." Patient C's history included giving birth to four children, undergoing a tonsillectomy and adenoidectomy at age 19, wisdom teeth extraction at age 32, and a motor vehicle accident at age 15 causing a left humerus fracture requiring surgery, two chest tubes, and the loss of her father. Respondent noted that her ADHD was previously

treated with Dexedrine 15 mg twice a day (BID), and that she had taken Adderall 30 mg 1 to 1 ½ tablets per day for fifteen years. Respondent documented a history of insomnia that was previously treated with Ambien, temazepam, Lunesta, and Sonata. Patient C had a history of anxiety that was previously treated with "all" benzodiazepines according to the record, most effectively treated with Klonopin 2 mg twice daily. Patient C worked at a renal dialysis clinic as a registered nurse. The review of systems was normal with the exception of ADHD, insomnia, anxiety, and daily grief. Respondent did not identify any current medications taken. Patient C's BMI was normal, and her blood pressure was elevated at 128/104. The general examination noted that her "mood appears euthymic, affect appropriate, insight excellent, and no suicidal or homicidal ideation." The assessment included a physical, ordering labs, severe ADHD, chronic insomnia, and chronic anxiety/grief. The plan was to treat Patient C with Adderall 30 mg bid, with a note that all her questions were answered, and that the risks and benefits were reviewed with Patient C before she agreed to proceed with treatment. Respondent prescribed Adderall 30 mg, #60, ½ to 1 tablet two times daily, which was handwritten and filled by Patient C. Patient C's EKG and CT calcium were normal except for a borderline Hgb A1C indicating borderline diabetes and a low TSH indicating possible hyperthyroidism. A CURES check by Respondent on this date in the medical record only revealed two prior prescriptions for Lunesta in 2019. Respondent documented a two page self-report scale completed by Patient C in support of an ADHD diagnosis, but the form noted that it was only a checklist and required a thorough clinical evaluation prior to a diagnosis of ADHD. Patient C signed an access to records form that listed Respondent as her husband, and allowed Respondent to receive medical information from other staff at the office regarding Patient C. Patient C refilled her Adderall prescriptions on September 9, 2020, October 21, 2020, and November 18, 2020. Patient C refilled her Phentermine 37.5 mg #30 on August 16, 2020, and September 26, 2020. Patient C filled her Xanax 2 mg #30 on November 5, 2020. The prescription records show that Respondent also prescribed propranolol 120 mg extended release daily, a one-year supply, clonidine .2 mg #270, with four refills. Notably, the record was not electronically signed by Respondent until October 19, 2020, over two months later.

28. On or about August 5, 2020, Respondent prescribed Patient C Adderall.

29. On or about November 4, 2020, at approximately 2330, a CHP officer observed Respondent driving northbound on US-395. The vehicle was intermittently stopping on the right shoulder, stopping approximately three times for five to ten seconds each time. The vehicle was fluctuating in speed between fifty and seventy miles per hour, and was the only vehicle on the roadway at the time. As the officer passed the vehicle, it began to intermittently activate the emergency flashers three times and the officers noticed that the vehicle registration was expired. Officers approached the vehicle and found that the interior of the vehicle was disheveled and drenched with a whitish liquid. Respondent, in the drivers seat, had severe red scratches on the top of his head that appeared fresh and nearly bleeding. Dr. Cook identified himself, and stated that his wife, Patient C, was completely inebriated and experiencing a manic episode. Respondent stated that she was acting out of control and sitting in the back of the vehicle naked. Respondent's eyes appeared red and watery, and his face was wet. Officers contacted Patient C who was seated in the middle of the third row seat of the Honda Pilot. Patient C was wearing clothes, her head appeared to have minor swelling, her hair was disheveled, and she stated that she was not naked. Officers asked Respondent to step out of the vehicle to provide a statement. Respondent told the officers that he had been married to Patient C for seven or eight months. He stated that they lived together in a home in Oakdale, and that their relationship was tumultuous. Respondent stated that Patient C was "completely inebriated and is experiencing a manic episode." Dr. Cook told them about a previous domestic violence situation that he and Patient C were both involved in three weeks prior in Stanislaus County. Respondent would not tell the officers what became of the Stanislaus County Sherriff's Department investigation or what reports were taken in the prior incident. Respondent stated that he and Patient C had travelled from Oakdale to Bishop, in order to visit her children. Respondent stated that they booked a room at the Creekside Inn in Bishop. He stated that on November 4, 2020, Patient C dropped her children off at an unknown location in Bishop and returned to the hotel. When she returned she was very upset, and Respondent stated that he could tell that she had been drinking. Respondent stated that he tried to console her, but she only became more aggressive and hit her own head on

the door in the hotel. Respondent would not tell the officers how he got scratches on his own head, but did say that it happened at the Creekside Inn earlier in the evening. Respondent stated that he hit Patient C, but admitted that he pushed her in self-defense as she approached him. Respondent stated that he spanked her on her 'bare bottom' as a punishment for out of control behavior. Respondent stated that he activated the emergency lights of the vehicle to get the attention of law enforcement because Patient C was continuing to act out of control. Respondent declined to provide the officers with any other detail.

30. The officers interviewed Patient C separately at the scene of the stop. Patient C sat in the right front passenger seat of the vehicle during the interview. Patient C stated that she had first met Respondent on May 24, 2020, after connecting online, and they now lived together in Oakdale. Patient C said that Respondent always says they are married, but they are not actually married. Respondent had thrown her out of the house several times in the past. She stated that they were staying at the Creekside Inn in located in Bishop while visiting with her children who live with their biological father. Patient C stated that they drove from Oakdale on November 2, 2020, and were returning home to Oakdale. In addition to seeing her children, she also attended a court appearance in Bishop during her trip. Patient C stated that Respondent had made her pack up all the belongings in the hotel room prior to returning to Oakdale. Respondent took her car and left. Respondent threatened to leave Patient C in Bishop with all her belongings. When Respondent returned to the hotel room and found that Patient C had not finished packing and cleaning, Respondent had become angry. Respondent called her children filthy and would not help her pack or clean the room. Respondent slammed the door in her face several times at the hotel. Patient C stated that Respondent had been "torturing" her for months, and had choked her many times before. Patient C stated that she just wanted to move back to Bishop. Patient C stated that while they were driving, Respondent tried to throw her out of the car, and eventually threw her cell phone out of the car. She stated that Respondent was punching her in the face, and demonstrated the punching in her face with her fists for the officers. She reported that he was also pulling her hair. Patient C stated that she was not afraid of Respondent right now, but she was earlier when they were driving. Patient C stated that she activated the emergency lights on

the vehicle to get help from law enforcement. She admitted to hitting Respondent in the face with a wet t-shirt in self-defense. During the interview officers observed a scratch and bruising on the top right of Patient C's forehead, and her face appeared to have minor swelling. Patient C's pupils appeared dilated, had a slow reaction to light, and she appeared to be avoiding eye contact when talking. Her speech was erratic, and she had difficulty recounting the events in chronological order.

31. On or about November 5, 2020, Respondent and Patient C were both arrested by the California Highway Patrol (CHP) for violation of Penal Code section 273.5 (co-habitant abuse). They were handcuffed, and transported to the hospital for a Covid-19 screening prior to incarceration. While traveling to the hospital, Patient C stated that she accidentally hit her head against the computer in the patrol vehicle, that the arrest was unjustified, and all the evidence should be sequestered. Patient C urinated in the patrol vehicle during transport to the hospital. While at the hospital, Respondent complained of chest pain, but declined medical attention. Officers were unable to get pictures of Patient C's injuries, but they took photos of Respondent's injuries. The parties were advised of their rights and admitted into the county jail.

32. On or about November 9, 2020, Sheriff's deputies contacted Patient C to conduct a follow-up interview regarding the prior allegation of rape against Respondent. Patient C, who was in jail during the interview, stated that she lied about being raped by Respondent because she was mad at the time. She stated that she was under the influence of marijuana, and had a lot of anxiety on that night. Patient C stated that she would obviously have sex with Respondent, as he was her husband. She added that she was under the influence of marijuana at the time she made the original report. Patient C said she was lying when she made the complaint of rape and wanted the charges to be dropped against her husband, Respondent.

33. On or about November 9, 2020, the Board received information from CHP that Respondent had been arrested for violation of Penal Code section 273.5 (co-habitant abuse) on or about November 5, 2020, and that during the investigation of this charge, Respondent admitted to being the primary care doctor for his new co-habitant, who he referred to as his wife.

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34. On or about November 17, 2020, the medical record contains documentation of discussions with the pharmacy regarding a refill of clonidine for Patient C. Although clonidine is typically prescribed as .2 mg every 6 hours as needed for a systolic blood pressure of 160, Respondent had only prescribed one pill per day.

35. On or about December 12, 2020 at 0750, Respondent texted Patient C stating "I will pray for you and you're going to need it you kidnapped me and locked me in my own room and house tonight you prevented me from leaving to exit away from the danger of you said such mean evil vile ruthless vindictive vicious things that it is unfathomable how you had any kind of relationship with anybody else..." Patient C responded by telling Respondent that it was an emergency and she needed him to prescribe her something so she could sleep. She then added that "Lunesta works best" followed by specifying that it should be in 3 mg tablets, or Xanax. Respondent stated, "No I will not prescribe any additional controlled substances for you ever again I already told you that...You need a psychiatrist and an addiction counselor...and rehab." Patient C persisted, telling Respondent that she was desperate. Respondent wrote, "I tried 100 times to help you last night and this morning every time you made promises that you broke every time you lied and did not provide what you kept promising... You are completely dangerous to me dangerous to you dangerous to everybody around you when you exited the driveway in my car and raced off with me holding onto the door handle you caught my hand in the door handle and ran over my foot." Patient C later asked him to pick up tobacco and medicine. She texted Respondent stating, "You torture me too." Respondent stated "I'm not talking with you you destroyed and tortured me to even be with you."

36. On or about December 12, 2020, at 0759, Respondent texted Patient C explaining that he had tried everything he could to help her, even providing a back rub and giving her "10 tablets of clonidine which would make any man sleep for days." Respondent called Patient C vicious and vindictive, and accused her of stealing his car key. The text conversation continued with Respondent suggesting that she should leave, and not call his office or his service anymore. Patient C referenced an old apartment, which Respondent described as, "an apartment in El Dorado Hills in which you said you took up seeing the high amounts of drugs and sat for days at a

time staring at the walls contemplating suicide....Obscene." Patient C later stated at 0803, "I have no choice I'm 100% depending on you." At 0806, Patient C texted, "I love you please bring my clonidine." Respondent replied by telling her that he is not able to help her and that she is beyond his ability to help any longer.

37. On or about December 12, 2020, the medical records note that Patient C was having a panic attack. Later notes indicate that her panic attack had improved, but that she was calling again, yelling about wanting to cancel her upcoming appointment with Respondent and fire him as a doctor. Following that entry, Patient C called again to ask Dr. W for a Xanax refill, claiming that she had received Xanax at Mammoth Lakes four day earlier. Patient C was directed to contact Respondent.

38. On or about December 15, 2020, at 1514, Patient C texted Respondent stating, "I think we should get married legally and say something like I moved away here for whatever reason and you are not financially helping me for the courts business and keep mine private." Respondent replied by marking her message as "loved." Patient C replied, "Just don't say anything about marriage to the courts." Patient C continued to text multiple times, later stating, that "being legally married is not important to you." She then stated that she is legally single. Following numerous texts from Patient C, Respondent asked her if she is back on methamphetamines at 1754. Patient C responded that she is done "playing married" with Respondent. Respondent discussed a marriage ceremony in Rosarito, Mexico, to which Patient C stated that she still wanted "a real wedding, a Christian wedding." At 1804, Patient C texted Respondent stating that "no amount of money could have bought my way out of dbhc [Doctors Behavioral Health Center, the mental health facility she was placed in following the 5150 hold]." Respondent replied, "Yes and I offered any amount of money to that doctor to keep you out of there... Then when they put you in there I argued with your doctor ... to let you out immediately for outpatient treatment....But you got there on your own merits I didn't put you in there..." Respondent later stated that he offered the doctor a month off to take her husband to Hawaii. Following numerous additional texts, Respondent recounted that Patient C was "active psychotic"

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and "running around in the front yard naked after an apparent suicide attempt." Patient C responded, "For you."

39. On or about December 15, 2020, at 1812, Patient C texted Respondent that she wanted valium because she "has to deal with her abusing boyfriend who lied and continues to lie" to her. Patient C then asked him for Adderall and said that if he is lucky he can stay her boyfriend and then they can get married in America. Respondent replied at 1817, "No amphetamines as you get psychotic." Patient C denied that she gets psychotic then told Respondent to leave the babies alone, and called him a trashy and filthy man in multiple text messages.

40. On or about December 22, 2020, at 0903, Patient C texted Respondent stating, "I will just plead guilty and tell the courts I am a liar and I'm not married to you then?" She added that this is related to her upcoming court date, that she will lie if that is what it takes, then claimed that he abandoned her again when he doesn't respond. Patient C stated that she should probably see a psychiatrist so that she doesn't steal medications anymore, and that she was hitting him in the first place because he stole her street medication. At 0944, Patient C said that she is going to cancel her appointment at his office "unless you can fill my narcotics please." She followed the text up with another that says just joking, with a question mark.

41. On or about December 22, 2020, at 1026, Patient C texted Respondent to tell him that he could have been eating breakfast with her, but instead she will be alone in jail. She stated, "No I see why attorney warned me [*sic*]." Respondent later disliked the statement about the attorney.

42. On or about December 23, 2020, at 0911, Patient C texted Respondent "911," followed by several pictures and a text that states, "Tell it to the police this time." At approximately 0915, Patient C texted Respondent stating "Good you have a daddy that loves you," followed by a text message that referenced Respondent's former step-daughter whom he is accused of committing sexual misconduct against. Patient C then said that she and the former step-daughter have the "same daddy and it's not [redacted]." At 0916, Respondent texted "coming here to institutionalize you." Respondent told Patient C that he received 240 texts from Patient C the day prior and that "it doesn't matter your still completely psychotic and drugged out

of your...on meth." At 0918, Patient C texted Respondent referring to the pending Accusation against Respondent alleging sexual misconduct and stated, "you're responsible." Respondent replied that she is sick, and Patient C stated "I'm Patient C[2] and you're gross negligence." Respondent replied, "You wish." Patient C continued to state that Respondent is "sick," that she knows it and his former wife (Patient A) knows it as well. Patient C stated, "You prey on me and [Patient B] and [Patient A]," followed by "Don't molest me." At 0921, Patient C texted Respondent, "No more molesting for you." Patient C continued to text Respondent repeatedly, to which Respondent stated at 0925, "I came home to you last night and you attacked me violently 20 times... I have the videos for the police." Patient C replied "Please don't touch my private." Patient C later texted that she has called 911 and the police for help, and that she hates Respondent.

43. On or about December 23, 2020, at 0941, Respondent texted Patient C accusing her of stealing money from his bank account and destroying his televisions in a recent "tirade." At 1255, Respondent texted, "I never confronted you last night... I just left after a dozen of your lunging attacks Also never struck back after 20 closed fist blows to my face and body while asleep at 2:00AM the night before and that is why I stayed to work late at the hospital last night!" Later the same day Patient C texted Respondent to state that she is "scared," she thinks her "brain is completely destroyed," and that she has no sense of self. She asked Respondent for help numerous times by text message.

44. On or about December 23, 2020, the medical records state that Patient C was suffering from a panic attack, and repeatedly was calling back and yelling at the staff on the phone calling them an incorrect name.

45. During the period of on or about August 5, 2020, through November 18, 2020, Patient C filled the following prescriptions for controlled substances:

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[2] At the time of this text message, the Board had not yet brought any allegations related to Patient C, and the patient appears to have self-identified as "Patient C" in reference to the allegations related to Patients A and B in pending Accusation No. 800-2017-039585.

Date Filled	Drug Name	Strength	Form	Days' Supply	Quantity	Prescriber Name
8/5/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
8/16/2020	PHENTERMINE HCL	37.5 MG	TAB	30	30	Respondent
9/9/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
9/26/2020	PHENTERMINE HCL	37.5 MG	TAB	30	30	Respondent
10/21/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
11/5/2020	ALPRAZOLAM	2 MG	TAB	30	30	Respondent
11/18/2020	MIXED AMPHETAMINE SALTS	30 MG	CER	30	60	Respondent

2021

46. On or about January 6, 2021, Patient C presented to Respondent due to a stress reaction while at her workplace, the dialysis clinic. Respondent stated in his interview, that the cause of the stress reaction was that employees at the dialysis clinic had spoken to Patient C about the allegations against Respondent in the pending Accusation involving sexual misconduct. Respondent noted that this had created a "toxic and hostile work environment," which aggravated her existing medical problems. The review of systems was negative except for anxiety. Patient C's medications listed include clonidine .2 mg, take 1-2 every 6 hours as needed for systolic blood pressure over 180, hold if less than 120; Adderall 30 mg BID, and as needed for severe ADHD. Patient C's vital signs revealed an elevated blood pressure of 140/98. The general examination was noted to be normal. The assessment includes a hostile work environment, toxic work environment with work-related stress reaction, generalized anxiety disorder secondary to panic and insomnia. The plan was to extend her time off from work through February 7, 2021. The forms were completed and sent to Patient C's employer. Respondent noted that Patient C was being treated by a psychiatrist who prescribed Seroquel 400 mg nightly for insomnia, that Patient C had begun counseling and had a session that night. Respondent noted that Patient C was scheduled to return in one week. Patient C continued to be on disability at Respondent's recommendation through April 14, 2021. The CURES report revealed that Respondent was

prescribing Patient C modafinil (a stimulant given for obstructive sleep apnea, narcolepsy or shift work sleep disorder) 200 mg #30, one daily. Dr. N, the psychiatrist that previously treated Patient C in San Diego, began treating Patient C by telehealth with Respondent present. Dr. N began prescribing Adderall 20 mg #30, one daily on May 2, 2021, eventually increasing it to 30 mg daily. Respondent continued to prescribe modafinil on May 20, 2021, until Dr. N began prescribing it on August 2, 2021.

47. On or about January 14, 2021 at approximately 2012 hours, police officers responded to a report of an altercation at the home shared by Patient C and Respondent. Respondent stated that his wife struck him and bent his fingers causing him pain. Patient C was on the phone with Respondent when officers arrived and could be heard yelling over the phone. Officers learned that Respondent and Patient C were married, had no children in common and lived together. Patient C initially denied any wrongdoing, then later admitted that she attempted to break Respondent's fingers and slapped him on the left side of his face. Patient C admitted to drinking tequila during the evening but denied using any illegal drugs. She told officers that Respondent had been molesting her since the beginning of their marriage. She stated that Respondent provides her with prescription sedatives, and she believe that she is being molested and manipulated. Patient C stated that initially, Respondent would give her a pill and say, "take this," so she would open her mouth and take it. She continued to take the pills, but began to wonder what Respondent was giving to her as they would make her tired. She told officers that Respondent has gone on dates with the daughters of other patients, and had seen pictures of children that were sent to him. She became erratic and was eventually placed under arrest. Respondent was provided with an emergency protective order against Patient C, and both parties were served with a copy of the order.

48. On or about February 19, 2021, Respondent obtained a restraining order against Patient C, that was effective for three years. Despite the order, he continued to have regular contact with Patient C.

49. On or about March 8, 2021, investigators contacted Patient C at the Stanislaus County Jail regarding the arrest of Respondent by the California Highway Patrol Bridgeport Office in

Mono County. Patient C voluntarily agreed to an interview. Patient C admitted that she is a substance abuser with drug-seeking habits that needs rehabilitation. Patient C stated that she would steal controlled substances from any source available. She stated that she stole benzodiazepine medications from Respondent's mother. She also stated that she has abused illegal drugs including heroin, methamphetamine, cannabis edibles, and Xanax (a benzodiazepine) that was purchased from the street. She stated that she is an abuser of oxycodone (an opiate) and Ambien (a sleeping pill) in combination, which she also obtains from the street. Patient C explained that she has been a habitual user of Adderall (a stimulant drug) since she was first prescribed Adderall at 17 years old. Patient C stated that she would purchase Adderall from the street and abuse the drug. Patient C stated that Respondent does not prescribe her opioids or benzodiazepines. In sum, Patient C stated that she was taking benzodiazepines, heroin, methamphetamine, cannabis edibles, Xanax, oxycodone, and Ambien. She stated that one time she stole ten thousand dollars from Respondent to purchase drugs and he caught her. As she tried to get away, the sheriff was called to her residence, which led to her current incarceration at Stanislaus County Jail. Patient C said that there had been multiple domestic violence calls to Respondent's residence near Oakdale, because she would behave out of control during her drug-induced frenzies. She insisted that Respondent is a good person and hopes to reconcile their relationship when she is released from jail and completes a rehabilitation program. Patient C repeated that she is not concerned with Respondent's behavior, and that it is her behavior that leads to contact with law enforcement. Patient C explained that on November 4, 2020, the day of the arrest in Mono County, she was in the middle of a drug-induced frenzy where she had consumed a vast amount of drugs including cannabis edibles, methamphetamine, Xanax (a benzodiazepine tranquilizer), and Ambien (a sedative/hypnotic). She stated that on that day she had consumed cannabis edibles and methamphetamine that was purchased on the street. Patient C added that she had consumed large quantities of Xanax and Ambien, some of which were purchased from the street, and some were stolen from Respondent's mother. After visiting with her children near the Bridgeport Indian reservation, she and Respondent took her children to the home of their father who had custody of the children following their divorce in 2019. Patient C

stated that it was late in the night after they dropped the children off, and she had to work in the morning in Modesto. Respondent drove them home during the night to their home in Oakdale. While Respondent was driving, Patient C reached into her pocket to take out a prescription bottle containing Ambien that she had previously stolen from Respondent's mother. Patient C said that she intended to take several pills to sleep on the way home. Respondent took the pills from her and put them in his front pocket. Patient C says that she became irate and aggressive and started physically fighting with Respondent while he was driving. Patient C reported that she tried to take the pills from his pocket while he was driving, causing the car to veer on the roadway. A CHP officer then investigated the incident and took statements from both of them. CHP arrested both of them and took them to the CHP office for fingerprinting. Patient C believes that it was all her fault and that the charges were dismissed.

50. On or about May 18, 2021, at approximately 2255, officers responded to the home shared by Respondent and Patient C due to a complaint of an altercation. When officers arrived, Respondent was in the front of his house wearing scrubs, a scrub hat, and a stethoscope and other items on a lanyard hanging around his neck. Respondent told officers that after the incident he changed into his work clothes. Respondent reported that he was lying in bed, nearly falling asleep, when Patient C entered the room and struck him in the face with a closed fist on his left cheek area. When he got up, she dumped a gallon of milk on to his head and on the bedroom floor. Respondent stated that Patient C was throwing household items at him in the room, and he waited outside for law enforcement. Respondent told officers that they had been married for about one year, and that Patient C was a heavy drinker. Patient C was arrested for domestic violence and taken to jail.

51. On or about June 4, 2021, Dr. N prescribed Patient C Seroquel, fluvoxamine, and gabapentin.

52. On or about August 18, 2021, Patient C's medical record noted that she had called the office and was incoherent. The notes stated that Patient C said "she had been in a Merced rehab, but left, had been in jail and was taken directly from jail to the rehab," loves Respondent, and

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"will do anything to save her marriage." Patient C requested to be referred to a rehab. A handwritten note adds, "I have been able to get [Patient C] back into Christian rehab."

53. On or about August 23, 2021 through October 19, 2021, Dr. G prescribed Patient C clonidine, gabapentin, trazodone, Lisinopril, Seroquel, and hydroxyzine.

54. On or about August 30, 2021, at approximately 1208, officers reported to the residence of Respondent and Patient C in response to complaints of spousal battery. Respondent told officers that he was sleeping when he awoke to Patient C punching and slapping his face. He stated that Patient C had broken into his residence, and stolen his vehicle, his wallet and $10,000.00. Patient C told officers that during the evening on August 27, 2021, she arrived at the residence and was punched and slapped multiple times by Respondent about her head, face, and leg areas. She told officers that she was living with Respondent and driving his vehicle for the past two years with his permission due to their sexual dating relationship. Patient C stated that she is a registered nurse that works in Respondent's office and sees his patients. She denied taking Respondent's wallet or his money, which Respondent later located during the interview. Both Respondent and Patient C told officers conflicting versions of a physical altercation on August 27 and again on August 29, 2021. Officers determined that Patient C was at the residence in violation of an existing stay away order listing Respondent as the protected party. Respondent was placed under arrest for committing battery against Patient C, then immediately complained of chest pains requiring a transport to the hospital. Patient C was placed under arrest for committing battery against Respondent, and for violating the active restraining order. The same day, officers responded to the residence and the hospital to take photos of Respondent and Patient C's respective injuries. Respondent complained of pain on his cheeks/jawlines, but the officer did not see any marks, bruises or injuries. Patient C complained of pain in her right shin, upper left back, left wrist, right abdomen, nose, and stated she was slapped on the right side of her head above her ear. The officer only identified a small bruise on her right shin.

55. On or about November 11, 2021, Patient C presented to the emergency room for possible broken glass in her foot. Patient C left before x-rays could be taken and declined a tetanus booster.

56. On or about December 6, 2021, Dr. N switched Patient C's ADHD medication from Adderall to Vyvanse 30 mg daily, which continued through June 16, 2022.

57. During the period of on or about February 1, 2021, through December 23, 2021, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Form	Days' Supply	Quantity	Prescriber Name
2/1/2021	MODAFINIL	200 MG	TAB	15	30	Respondent
3/23/2021	MODAFINIL	200 MG	TAB	30	30	Respondent
4/21/2021	MODAFINIL	200 MG	TAB	30	30	Respondent
5/2/2021	AMPHETAMINE SALT COMBO	20 MG	TAB	30	60	Dr. N
5/20/2021	MODAFINIL	200 MG	TAB	15	30	Respondent
6/23/2021	MIXED AMPHETAMINE SALTS	30 MG	CER	30	30	Dr. N
8/2/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
9/21/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
10/21/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
12/6/2021	VYVANSE	30 MG	CAP	14	14	Dr. N
12/23/2021	VYVANSE	30 MG	CAP	30	30	Dr. N

2022

58. On or about March 10, 2022, Respondent documented that Patient C had a negative PAP smear, negative HPV test, negative for sexually transmitted infections, negative for bacterial/trichomonas/fungal tests, negative urinalysis and culture, normal blood tests, elevated potassium of 6.1, elevated calcium of 10.6, mildly elevated liver enzyme of 41, and a normal TSH.

59. On or about May 10, 2022, the Board of Registered Nursing, Department of Consumer Affairs, filed an Accusation against the Registered Nurse License issued to Patient C. The Accusation was related to Patient C's criminal conviction for driving under the influence of alcohol on July 4, 2019; Patient C's dangerous use of alcohol during police contacts with Respondent on September 18, 2020, January 14, 2021, February 14, 2021; and unprofessional conduct during domestic violence incidents and violation of a restraining order related to her contacts with Respondent on January 14, 2021, February 14, 2021, February 29, 2021, August 7,

2021, and August 30, 2021. Patient C subsequently admitted the truth of each and every charge and allegation in the Accusation, and surrendered her Registered Nurse License effective December 6, 2022.

60. On or about May 25, 2022, the chart indicates that Patient C failed to show for an appointment. A note indicates that she had called to cancel the appointment.

61. On or about June 21, 2022, Patient C presented to Respondent for treatment. Respondent documented a significantly more complete patient history than what was included in the first visit. Respondent mentioned urgent hypertension since 2018, post-traumatic stress disorder, panic and anxiety issues since age 5-6 exacerbated by her father's death when she was fifteen. Respondent mentioned severe insomnia and severe shift work sleep disorder since age 4, a learning disability, a mood disorder with night sweats and nightly terrors. Respondent noted that Dr. N has followed her for ten years. The records indicate that Patient C had seasonal allergies and asthma since age two. Respondent wrote that she "denies significant alcohol, tobacco, or drugs," although in his interviews with police Respondent stated that she was quite inebriated during her November 4, 2020 arrest. Respondent stated that Patient C attended Celebrate Recovery weekly at her church. The record states that Patient C's uncle died by suicide at age 30, and her brother was disabled and had multiple psychiatric problems. Respondent documented that substance abuse history and mental health history was last reviewed on April 26, 2022, but no record of this exists in her medical record. Patient C's medications were clonidine, modafinil, Seroquel, propranolol, amoxicillin, pyridium, bimatroprost eye drops, Phenergan suppositories. The examination shows no vitals or examination information other than a partial urine dipstick result. The assessment was a painful and frequent urination, and vaginal discharge. This visit was not signed electronically by Respondent.

62. On or about June 22, 2022, Patient C failed to show for an appointment. Labs were performed on this date that were negative for STI's, bacterial infections, parasite infections, but positive for a yeast infection.

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63. On or about July 7, 2022, Patient C presented for her final documented visit. Respondent did not document a patient history, just mention of the previous visits with the addition of metronidazole topical gel applied to the affected area daily. The examination only included vital signs, showing an increase in weight to 153.6 pounds. Respondent did not sign off on this visit electronically.

64. On or about July 7, 2022, investigators interviewed an employee at Respondent's office. The employee stated that Patient C was known to live with Respondent and would come into the office daily. Patient C appeared to be "high" about half of the time, but would usually stay in Respondent's office. The employee stated that Patient C's hair was matted down and she was regularly dressed in age inappropriate clothing – similar to something a 3 or 4 years old child would wear. On other occasions, she would wear medical scrubs while she was in the office. One time, she found Patient C spinning and dancing through the hallways of the medical practice. Another time, around February 2022, she had to help Patient C go the bathroom and return to Respondent's couch because she was too impaired to walk on her own.

65. On or about July 7, 2022, investigators interviewed the office manager at Respondent's practice. The office manager reported that it was her understanding that Patient C was Respondent's common law wife, and that she was in the office all the time. Patient C was regularly "completely out of it" at the office, and was required to stay in Respondent's private office. She believed that Patient C was nice, but would suddenly fly off the handle and become volatile. She told Respondent that Patient C should not be allowed to wander around the office, but she had to redirect Patient C back to Respondent's office several times. Respondent told the office manager that Patient C had been in rehab before, and that she was abusive towards him. The office manager provided investigators with two emails that she received from Respondent on October 23, 2020 that were intended for Patient C, but accidentally sent to her email. In one Respondent told Patient C, "You have deceived me again. Never again will I ever believe you or trust you. You love your methamphetamine and your drugs more than you love your family more than you love your own children. You love methamphetamine and black tar heroin more than you love God and his promises to us…his children." In another he wrote Patient C, "Your two

tablets here at the house and will give it to you right now turn your car around and come back now. I will give you five tablets right now! Do not buy more GHD [*Sic*] do not buy more black tar heroin do not buy more methamphetamine..."

66. On or about July 7, 2022, investigators interviewed a Physician Assistant working with Respondent at the medical practice. The Physician Assistant stated that she believes that Respondent is a pathological liar and should not be practicing medicine. She explained that he frequently left the building, leaving her to treat all of his patients alone. It was her understanding that Patient C met Respondent in July 2020 and participated in a commitment ceremony in Mexico, but that they were not legally married. She stated that Patient C was normal during the first two weeks she was in the office, but then engaged in increasingly unstable behaviors. The Physician Assistant is very concerned about all of the medications prescribed by Respondent to Patient C, especially the prescription for phentermine while Patient C only weighed 121 pounds. The Physician Assistant recalled that when Patient C was first seen on August 5, 2020, she was immediately started on Adderall and Phentermine. The only thing she saw recorded in the chart records at that time were a set of vital signs. She believes that Respondent added new information to the chart record in October 2020 well after the visit, and does not believe any of Respondent's entries in Patient C's medical chart. The Physician Assistant also believes that Respondent altered the chart notes for the visit on June 24, 2022. The Physician Assistant related that Respondent obtained a restraining order against Patient C, but did not follow it. The Physician Assistant stated that Patient C would live at the office every day, would scream at Respondent in the office, would call him as many as 70-80 times a day, and text him 20-98 times a day while he was in the office[3]. The Physician Assistant reported that Respondent asked her to review Patient C's chart shortly after it was requested by the Medical Board for review. She refused to review Patient C's medical chart because she believes that Respondent's records were inaccurate. The Physician Assistant fears that Patient C is at risk of dying in the future due to causes related to Respondent's prescribing.

[3] She said she knew the messages were this frequent because Respondent leaves his phone on the counter in the office and she could see his messages.

67. On or about July 7, 2022, investigators interviewed a receptionist at Respondent's office. The receptionist stated that Respondent would alter her notes and records in the electronic health record relating to Patient C. After she discovered this she began signing her notes to prevent Respondent from changing the records. The receptionist related that while Patient C was in the office the staff began to notice items missing from their purses and suspected Patient C. She recalled Patient C often appearing to be "high" on medications while in the office.

68. On or about July 7, 2022, investigators interviewed a medical assistant at Respondent's office. She reported that Patient C was regularly in the office the entire eight hour workday and cause a great deal of drama. One time, Patient C asked her and another medical assistant to take pictures of her nude body in an examination room to document the abuse caused to Patient C by Respondent. The medical assistant reported that one day Patient C called the front desk 45 times to get Respondent to talk to her. The medical assistant took the pictures, but then they contacted the local Sheriff's Department to report the abuse. On July 7, 2022, when investigators made an unannounced site visit to the practice, Patient C was in the building but stepped out the back door when the investigators arrived. The medical assistant knew that Respondent was prescribing Seroquel, Adderall, and phentermine to Patient C. Shortly after the Medical Board requested Patient C's medical record, Respondent asked the medical assistant to review Patient C's chart to see if it "looked good," but she refused.

2023

69. On or about February 7, 2023, Respondent participated in a subject interview regarding his care and treatment of Patient C. Respondent stated that Patient C is his wife, and he would "do anything to try to help her." Respondent stated that Patient C asked him to prescribe her the same medications that she previously received from Dr. N, and that he agreed to do so only until she started seeing Dr. N again, at which time he would only provide local care. Respondent described an arrangement that was made with Dr. N during their first phone call together for Dr. N to handle all of the prescribing related to Patient C's psychiatric medicine, and Respondent would handle her primary care. Respondent claimed that there were "probably several times' where Patient C was unable to reach Dr. N and needed an emergency refill of

something, so he would prescribe a controlled drug to Patient C. Respondent claimed that when, on August 5, 2023, he prescribed her Phentermine 11 days after prescribing Patient C Adderall, that he "had no knowledge of substance abuse." Respondent claimed that he asked for Dr. N to provide him records from her chart regarding Patient C, but he never received them. Respondent claimed that Patient C hid her history of substance abuse from him until June of 2022. Later in the interview, Respondent admitted that he learned that Patient C was using CBD gummies and alcohol on September 28, 2020, the night she was place on a psychiatric hold due to a possible overdose. Respondent maintained that he saw no problems in treating Patient C, despite the fact of their intimate and volatile relationship. Respondent maintained that he could maintain complete objectivity in the treatment of Patient C, and even stated that his care was better than any other physician, because he could provide 24/7 monitoring for Patient C. Respondent claimed that he was not aware of Patient C's illicit drug use issues until approximately June of 2022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

70. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of Patient C. The circumstances are set forth in paragraphs 24 through 69 above, which are incorporated by reference as if fully set forth. Additional circumstances are as follows:

71. Respondent claimed in his subject interview that he was unaware that Patient C was a drug addict until June 2022, despite observing firsthand for more than two years her numerous manic episodes, intoxication, arrests, alleged physical attacks, and obsessive texts and phone calls. Respondent knew from the beginning that Patient C was a drug addict, and continues to cover for her. The standard of care for physicians is to not prescribe controlled substances to a known addict, except in cases where the physician has special training in addiction medicine or is part of a program such as a methadone clinic. Respondent prescribed to Patient C, a known drug addict, for two years, which constitutes an extreme departure from the standard of care.

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Respondent's prescribing contributed to Patient C's drug addiction and delayed effective management of her addiction, causing harm to Patient C.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

72. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts in the care and treatment of Patient C. The circumstances are set forth in paragraphs 24 through 71 above, which are incorporated by reference as if fully set forth. Additional circumstances are as follows:

73. Despite Respondent's claim that he could maintain objectivity, the evidence is clear that Respondent was not objective in comprehending Patient C's many problems, and in fact concealed her problems. Respondent claimed that he was not aware of Patient C's drug use issues until June of 2022, but the evidence establishes that this is untrue. On November 4, 2020, Respondent told police officers that Patient C was inebriated. On December 15, 2020, Respondent texted Patient C to question if she was back on methamphetamines. On September 28, 2020, Respondent told the police that Patient C took an overdose of clonidine. On December 23, 2020, Respondent texted Patient C to say that she was "completely psychotic and drugged...on meth." On May 18, 2021, Respondent told police that Patient C consumed two bottles of wine and unknown powdery drugs. Respondent minimized Patient C substance abuse by stating that it was only cannabis edibles with CBD, because many also contain THC, the hallucinogenic component of marijuana, and edibles can stay in the system for 12-24 hours. Respondent did not recognize that Patient C had no need to purchase CBD edibles on the street unless she was seeking THC-containing edibles. Respondent did not recognize that Patient C's CURES revealed a history of possible substance abuse before he started prescribing Adderall. Respondent was oblivious to Patient C's disruption of the medical office when the behavior was so evident to others working in the office.

74. The standard of care for a physician and surgeon is to avoid treating immediate family members due to numerous challenges including concerns about professional objectivity, patient autonomy, and informed consent. Respondent continued to treat Patient C, unaware of his

own lack of objectivity in managing her complex case. Respondent minimized, excused or covered over Patient C's issues. Patient C was unable to free herself from Respondent's treatment in order to obtain objective dispassionate care elsewhere. Respondent departed from the standard of care in his continuous treatment of Patient C. Respondent's treatment of Patient C contributed to her drug dependency, constricted lifestyle, and enmeshed himself into her ongoing problems. Respondent's treatment caused harm to Patient C.

75. The prescription of Clonidine to Patient C prescription required checking Patient C's blood pressure at least four times a day, but Respondent did not maintain any corresponding records to support that her blood pressure was regularly checked. Respondent greatly undertreated Patient C's hypertension, which required daily medicine to keep her blood pressure lower than 140/90. Respondent documented two elevated blood pressure readings while Patient C was already on medication for her blood pressure, but Respondent did not document any notes related to the readings and stated at his subject interview that he did not consider them. Respondent prescribed propranolol on June 21, 2022, presumably to treat hypertension, but did not take a blood pressure reading on that date. The prescription records show that propranolol was not filled by the patient until November 2020. Patient C's labs from August 5, 2020 reveal possible hyperthyroidism, which can cause agitation and many psychiatric symptoms, but Respondent made no mention of the abnormality and did not make plans for any follow-up. Patient C's potassium level was elevated in March of 2022, but Respondent never rechecked it. Patient C's calcium level was abnormally high in March of 2022, which required follow-up to rule out hyperparathyroidism, but Respondent never rechecked it. Patient C's liver enzymes were elevated in March of 2022, which necessitated a follow-up to rule out alcoholic liver injury or hepatitis, but Respondent did not recheck Patient C. Patient C presented with insomnia, but Respondent prescribed Modafinil, which is typically used for sleep apnea or narcolepsy, conditions not identified in Patient C. Respondent failed to coordinate for routine care of Patient C including regular breast exams and mammograms. Patient C presented to Respondent with significant psychosocial problems and multiple medications, often in combination with others, but Respondent failed to maintain detailed documentation of Patient C's treatment and referrals to

specialist providers. Respondent claims that he performed regular drug screens for Patient C, at his home, but failed to document those in the medical records.

76. Respondent's management of Patient C was primarily focused on her psychiatric issues. Respondent did not expand his problem list to include other concerns until he added a urine infection/vaginal discharge on June 21, 2022. Patient C presented with significant hypertension, for which Respondent prescribed Clonidine for a systolic pressure above 180 four times daily.

77. The standard of care for a primary care provider is to properly delineate all medical problems, obtain a proper history and physical, discuss all medical problems, order treatments for all problems, and engaged in a careful follow-up to assess the effectiveness of treatment. Respondent failed to document a complete problem list, undertreated Patient C's hypertension, and prescribed medications for medical problems absent documentation to support the prescribing. Respondent failed to involve a local specialist in managing Patient C's complex psychosocial problems. Respondent departed from the standard of care in managing Patient C's complex array of medical problems. Respondent's treatment of Patient C caused her harm by failing to properly treat her hypertension, and failing to adequately explore other medical concerns including her thyroid, parathyroid, and liver.

78. The standard of care is to carefully assess each and every medication prescribed to a patient, especially looking for harmful interactions when multiple medications are prescribed concurrently. Respondent failed to maintain well-documented records that stated his rationale for prescribing to Patient C. Respondent failed to appreciate the significant interactions that can occur in Patient C's poly-pharmacy and did not closely monitor for reactions to the medications. Patient C experienced a number of drug-induced frenzies when her medications were combined with alcohol, marijuana, and methamphetamine. Respondent failed to adequately document the rationale and effect of medication interactions in the care provided to Patient C, which constitutes a departure from the standard of care. Respondent's prescribing poly-pharmacy to Patient C caused her harm.

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79. Respondent treated Patient C for a two year period that included regular prescribing, but only three patient visits. The first on August 5, 2020, established Patient C as a Patient and marked the beginning of her prescriptions for Adderall. The second visit, on January 6, 2021, was scheduled to place Patient C on disability and remove her from her work. The third appointment, on June 21, 2022, was to treat Patient C's complaint of a vaginal discharge and possible urine infection. The fourth visit, on July 7, 2022, was cut short due to an unannounced office investigation by the Medical Board, during which Patient C escaped out the back of the office without engaging with investigators. Respondent did not fully appreciate Patient C's vitals on the first two visits, and the documented medical assessments were incomplete. Respondent's discussion of the treatment plan was too brief, only stating what medication would be prescribed. Respondent never documented a single chart record between visits to explain the prescribing of additional medications. Respondent claims that he provided treatment to Patient C at his home, but no records are documented in her chart. Respondent failed to maintain a list of all medications prescribed, and the date each medication was discontinued. Respondent stated that he requested documents from Patient C's psychiatrist, but they were never obtained, and Respondent failed to document a synopsis of the conversations with the psychiatrist.

80. The standard of care for managing patients is to maintain clear medical records, including a history, physical examination, assessment of all patient problems, a plan of treatment, documentation of follow-up visits, labs, x-rays, EKG's, specialist's notes and other therapeutics affecting the care of the patient. Respondent failed to maintain adequate medical records in the care and treatment of Patient C, which constitutes a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Recordkeeping)

81. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under sec section 2266, in that he failed to maintain adequate and accurate records of his care and treatment of Patient C. The circumstances are set forth in paragraphs 24 through 80 above, which are incorporated by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60965, issued to Mark Daniel Cook, M.D.;

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

3. Ordering Mark Daniel Cook, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Mark Daniel Cook, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: MAR 17 2023

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

FR2020300931
95494876

Exhibit C

Accusation No. 800-2021-083681

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

In the Matter of the First Amended Accusation Against: **Mark Daniel Cook, M.D.** **1425 West H St. Ste. 200** **Oakdale, CA 95361** **Physician's and Surgeon's Certificate No. A 60965,** Respondent.	Case No. 800-2021-083681 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's Certificate No. A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2024, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

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

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

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

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

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

9. The California Immunization Registry (CAIR) is a secure, confidential, statewide computerized immunization information system for California residents. The registry is accessed online to help providers and other authorized users track patient immunization records, reduce missed opportunities, and immunize Californians of all ages. The greater San Joaquin Valley utilizes the Regional Immunization Data Exchange (RIDE) system to access patient immunization records.

FACTUAL ALLEGATIONS

10. On or about September 2021, an employee at Oakdale Family Practice (OFP) noticed expired COVID-19 vaccine vials on the desk in Respondent's office. The employee notified other employees, who found the information noteworthy as OFP had decided not to administer COVID-19 vaccines due to storage issues. The employees saw the expired vaccine vials and later found discarded vaccine cards in the shred box. Employees had heard Respondent state that he was against Covid vaccinations, and wouldn't get one himself. Employee E.S. began copying vaccination records of patients who presented for Covid vaccines from Respondent, and believed that the patients were getting vaccine cards without actually getting the vaccination. Respondent treated some patients, not established with OFP, by providing Covid vaccinations for cash, but would not maintain any medical records for the visits.

11. On or about November 24, 2021, E.S. filed an online complaint with the Board alleging that Respondent was engaging in unprofessional conduct, including maintaining expired COVID-19 vaccine vials in a mini refrigerator in his office.

12. On or about July 7, 2022, Board investigators conducted a site visit of OFP. During the inspection, the investigators examined and photographed the mini-fridge in Respondent's office. The mini-fridge contained a small box that included three vials of Covid vaccines. The expiration date on the box was listed as April 27, 2022. There were no other objects in the mini-fridge. The mini-fridge had a temperature device on the door, connected to wires that went inside the mini-fridge. The current temperature of the mini-fridge during the inspection read 24.4 degrees Celsius or 75 degrees Fahrenheit. The word "MAX" appeared directly above this reading. The mini-fridge contained a freezer section that had no door and was covered in significant frost accumulation that extended beyond the doorframe and outside the mini-fridge. The vials were in the back of the freezer section, and a wire was attached to a probe halfway into the upper section of the mini-fridge on the side. The mini-fridge contained three Janssen vials, five doses/vial, two on their side appearing full of clear fluid with intact blue protector caps, and one full vial whose blue protector cap had been removed.

13. During the office visit, numerous employees of OFP were interviewed. The office manager, A.Y., stated that Respondent was very vocal that Covid was a "farce." She stated that she never gave Covid vaccines, never witnessed any vaccinations in the office, and was not aware that he was administering vaccines to patients, but knew that he had a mini-fridge in his office. Another physician in the office, G.K., stated that Respondent made many anti-vaccination comments and she believed that he was against the Covid vaccine.

14. A physician assistant, C.C., explained that she believed Respondent received a government grant of $55,000 to administer Covid vaccines, and that he administered them to patients from the supply in his mini-fridge. She was not aware of any instances in which Respondent provided expired vaccines to patients. C.C. stated that she did not have access to the mini-fridge or the RIDE system, and she had only provided a handful of Covid vaccinations herself.

15. A medical assistant, H.S., stated that OFP was not providing vaccinations to patients. H.S. stated that she was regularly using the RIDE system to document other vaccinations and noticed that Respondent had administered 70-80 vaccinations in the system. H.S. thought this

was strange because she believed that Respondent was against the vaccination, and there were no chart notes in the medical records for the patients when the vaccinations were administered. H.S. was aware that Respondent held travel clinics where he administered the Covid vaccine, but she never saw him administer one in person. H.S. stated that Respondent kept expired vaccines in the mini-fridge, and she didn't know how the temperatures were regulated or maintained. Numerous other employees told investigators OFP did not provide vaccinations.

16. According to the RIDE system, several patients received the Jannsen COVID-19 vaccine from Respondent.

Patient 1[1]

17. The RIDE system indicates that Patient 1 received the Covid vaccine from Respondent on October 4, 2021. In a phone interview, Patient 1 confirmed that she received the vaccine and reported a history of Guillian-Barre syndrome, seizures, and stroke. Patient 1's medical records for September 9, 2021, through October 6, 2021, were reviewed but contained no discussions or documentation of the Covid vaccination. In the medical records section for immunizations, it states "none."

Patient 2

18. The RIDE system indicates that Patient 2 received the COVID-19 vaccine from Respondent on October 23, 2021. Patient 2's medical records from OFP show that he had office visits on September 29, 2021, and October 11, 2021; telehealth appointments on September 22, 2021, to discuss Covid questions; and October 1, 2021, for Covid vaccine questions. The records contain a negative test for COVID-19 antigens on October 5, 2021, and the telehealth notes refer to a discussion of a vaccine exception and a history of Guillian-Barre in childhood. The medical records contain no documentation of the COVID-19 vaccination or a discussion of the risks and benefits of the COVID-19 vaccination.

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[1] All patients referenced in this Accusation are referred to by number to protect their privacy.

Patient 3

19. On or about September 19, 2021, according to the RIDE system, Patient 3 received a Covid vaccine.

20. On or about November 8, 2022, Patient 3 spoke with investigators by phone and confirmed that he received the COVID-19 vaccine from either Respondent or his Physician Assistant (PA). Patient 3's records from OFP show three office visits on September 16, November 23, and November 29, 2021. Multiple vaccinations are mentioned in his medical record, but there is no documentation of the COVID-19 vaccine. The medical records contain no documentation of the COVID-19 vaccination or a discussion of the risks and benefits of the COVID-19 vaccination.

Patient 4

21. Patient 4 received a Covid vaccine from Respondent on October 4, 2021. He had office visits at OFP on September 22, and October 4, 2021, and a negative antibody test on September 22, 2021. The medical records contain no documentation of the COVID-19 vaccination or a discussion of the risks and benefits of the COVID-19 vaccination.

Patient 5

22. Patient 5 received a Covid vaccine from Respondent on October 23, 2021, in her left deltoid. The vaccine logs documented the vaccination and the location where it was administered, but contained no other information regarding informed consent or Patient 5's medical history. OFP does not have any patient medical records other than the vaccine log for Patient 5. Respondent did not document any information relating to Patient 5's COVID-19 vaccination and did not document any discussion of the risks and benefits of the COVID-19 vaccination with this patient.

All Patients

23. On or about February 27, 2021, shortly after the Janssen Covid vaccine was released under an emergency use authorization to provide immunity for patients against the Sars-CoV-2 virus, reports of blood-clot disorders and higher-than-expected cases of Guillian-Barre syndrome appeared. This resulted in a brief pause in the administration of the vaccine, then a resumption of

vaccinations with precautions. This underlies the importance of carefully documenting informed consent when administering this vaccine to at-risk patients.

24. Respondent did not document any provision of informed consent when administering the Sars-CoV-2 vaccine to his patients. Respondent did not document the administration of the vaccine to his patients in the patient medical records. Respondent did maintain a hand-written vaccine log that mentions the patient, identifying information for the patient, the site of administration, and the lot number, but it does not contain any information relating to informed consent. The RIDE documents do not provide any documentation regarding the provision of informed consent to patients regarding the Sars-CoV-2.

25. Respondent received Jannsen (Johnson and Johnson) Sars-CoV-2 vaccines for administration to his patients. The Jannsen vaccine was shipped at 34 to 46 degrees Fahrenheit and must be stored at the same temperature. If they are frozen upon arrival, they must be thawed for 1 to 2 hours prior to administration, and cannot be allowed to freeze again, which is something that can occur in a mini-fridge when stored on a cooling coil and protected from light. An un-punctured vial can be stored for 12 hours if kept at 47-77 degrees Fahrenheit. A punctured vial can be stored for up to six hours at 2 to 8 degrees C, or at room temperature for only up to two hours. The vial is to be discarded if not used during these time limits, even if unused doses are wasted if not used. While provisions for maintaining Jannsen vaccines for additional months past the listed expiration date exist, they only apply to properly stored and un-punctured vials. Respondent stored his vaccines in a mini-fridge, which is specifically disallowed by the vaccine manufacturer. The American BioTech Supply Company stated, "The CDC prohibits storing vaccines in dormitory-style, bar-style, or combined refrigerator/freezer units under all circumstances, even temporarily. Dorm-style refrigerators have one exterior door and an evaporator plate (cooling coil) located in the icemaker compartment. The units also exhibit extreme temperature stability issues in storage areas. They also pose a risk for short and long-term freezing. Facilities cannot use these appliances to store vaccines bought with public funds." The photographs of Respondent's mini-fridge reveal frost buildup that can prevent a good air seal and a temperature of 76 degrees Fahrenheit on the monitor device. The temperature alone would

have required the three punctured vials to be discarded within 12 hours. Respondent failed to maintain a temperature log. Respondent failed to employ proper vaccine storage protocols and to rigorously monitor the conditions to ensure the effectiveness of the vaccines.

26. On or about February 7, 2023, Respondent spoke with investigators during their inspection of OFP. Respondent stated that he commonly treats 35-40 patients per day, and one time treated 78 patients in a single day. Respondent said that he received an $11,500 personal grant from the Stanislaus County Health Department to order and administer COVID-19 vaccines. He picked up the refrigerated vaccines himself and stored them in his mini-fridge because he didn't want to share the vaccines with other physicians. Respondent stated that he gave all of the vaccinations, other than a few that were provided by his PA, and he never administered an expired vaccine. Respondent stated that the vaccines were free, so he did not charge patients anything to administer the vaccination. Respondent claimed that he documented discussions with patients regarding the COVID-19 vaccination, especially for patients that were at risk, and that he would provide that information as it was not in the progress notes, patient charts, or vaccine logs.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

27. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence in the management, storage, and administration of the COVID-19 vaccine. The circumstances are set forth in paragraphs 11 through 26 above, which are incorporated by reference as if fully set forth. Additional circumstances are as follows:

28. Respondent utilized an improper refrigerator to store his Sars-CoV-2 vaccines. Respondent failed to employ sufficiently rigorous protocols to ensure the effectiveness of his vaccines for patients. Respondent risked the possibility of administering inactivated Sars-CoV-2 vaccines to patients due to improper storage. Respondent's management of the Sars-CoV-2 vaccine constitutes an extreme departure from the standard of care.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5. The circumstances are set forth in paragraphs 11 through 28 above, which are incorporated by reference as if fully set forth. Additional circumstances are as follows:

30. Respondent failed to document any provision of informed consent prior to administering COVID-19 vaccines to patients. Respondent failed to document the administration of the vaccines in patient medical records. Respondent claims that he carefully discussed the risks, benefits, and potential side effects of the vaccines with patients, but he did not document any discussion in the medical records. Respondent's failure to document informed consent related to the Covid vaccine in the treatment of Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5, constitutes a separate departure from the standard of care for each patient.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Records)

31. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records of his care and treatment of Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5. The circumstances are set forth in paragraphs 11 through 30 above, which are incorporated by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 60965, issued to Respondent;

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

3. Ordering Respondent, to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

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

DATED: NOV 30 2023

Jenna Jones for
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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