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

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| In the Matter of the First Amended Accusation Against:<br><br>Dwight William Sievert, M.D.<br><br>Physician's and Surgeon's Certificate No. G 47593<br><br>Respondent. | Case No.: 800-2020-067784 |

## DECISION

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

This Decision shall become effective at 5:00 p.m. on October 09, 2024.

IT IS SO ORDERED: September 9, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
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*Attorneys for Complainant*

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

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| In the Matter of the First Amended Accusation Against:<br><br>**DWIGHT WILLIAM SIEVERT, M.D.**<br>**7766 N. Palm Ave., Ste 107**<br>**Fresno, CA 93711-5734**<br><br>**Physician's and Surgeon's Certificate No. G 47593**<br><br>Respondent. | Case No. 800-2020-067784<br><br>OAH No. 2024020346<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the First Amended Accusation.

## PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Lynette D. Hecker, Deputy Attorney General.

2. Respondent Dwight William Sievert, M.D. (Respondent) is represented in this proceeding by attorney Marvin Firestone, M.D., J.D., whose address is: 1700 South El Camino Real, Ste. 408, San Mateo, CA 94402-3050.

3. On or about June 14, 1982, the Board issued Physician's and Surgeon's Certificate No. G 47593 to Dwight William Sievert, 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 First Amended Accusation No. 800-2020-067784, and will expire on May 31, 2026, unless renewed.

**JURISDICTION**

4. First Amended Accusation No. 800-2020-067784 was filed before the Board, and is currently pending against Respondent. The initial Accusation and all other statutorily required documents were properly served on Respondent on July 25, 2023. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on December 21, 2023. Respondent timely filed his Notice of Defense contesting then First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2020-067784 is attached as "Exhibit A" and incorporated herein by reference.

**ADVISEMENT AND WAIVERS**

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2020-067784. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

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

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2020-067784, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. 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. 800-2020-067784, a true and correct copy of which is attached hereto as "Exhibit A," and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 47593 to disciplinary action.

## RESERVATION

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

## CONTINGENCY

13. 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.

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

15. 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. 800-2020-067784 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.

16. 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.

17. 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 G 47593, issued to Respondent DWIGHT WILLIAM SIEVERT, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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.

2. 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.

3. 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 $35,000.00 (thirty-five 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. 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).

4. 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.

5. 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.

6. 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.

7. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training

program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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; and Quarterly Declarations.

8. 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.

9. 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.

10. 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.

11. 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.

12. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2020-068666 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, Marvin Firestone, MD, JD. 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: _____

DWIGHT WILLIAM SIEVERT, M.D.
*Respondent*

I have read and fully discussed with Respondent Dwight William Sievert, 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: _____

Marvin Firestone, MD, JD
*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

LYNETTE D. HECKER
Deputy Attorney General
*Attorneys for Complainant*

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Marvin Firestone, MD, JD. 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: 7/1/2024

DWIGHT WILLIAM SIEVERT, M.D.
*Respondent*

I have read and fully discussed with Respondent Dwight William Sievert, 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: 7/2/2024

Marvin Firestone, MD, JD
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: 7/2/2024

Respectfully submitted,

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

LYNETTE D. HECKER
Deputy Attorney General
*Attorneys for Complainant*

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**BEFORE THE**
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| In the Matter of the First Amended Accusation Against:<br><br>**Dwight William Sievert, M.D.**<br>**7766 N. Palm Ave., Ste. 107**<br>**Fresno, CA 93711-5734**<br><br>**Physician's and Surgeon's Certificate No. G 47593,**<br><br>Respondent. | Case No. 800-2020-067784<br><br>**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).[1]

2. On or about June 14, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 47593 to Dwight William Sievert, M.D. (Respondent). The Physician's

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[1] Mr. Varghese was Interim Executive Director when the original Accusation was filed.

and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2024, unless renewed.

**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 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.

6. 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**

7. 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.

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## FACTUAL ALLEGATIONS[2]

**Circumstances Related to Patient 1**

8. On or about October 13, 2018, Patient 1[3] presented to Respondent with a chief complaint of "anxiety, depressed mood, irritable, appetite disturbance, low energy, fatigue." Further complaints included inability to sleep despite fatigue. Respondent did not document current medications, medication allergies, or past medical history. A diagnosis of "Lymes and Epstein Barr virus" was entered into the chart, but Respondent did not document any additional information about these conditions. Respondent diagnosed major depressive disorder, severe, recurrent, and prescribed temazepam 30 mg, a benzodiazepine[4,5] and Pristiq, an antidepressant medication.

9. Patient 1 followed up in or around November 2018 and in or around January 2019, and Respondent continued Patient 1's medications. On or about February 12, 2019, Respondent discontinued Pristiq, and eszopiclone, a Schedule IV sedative, was added to temazepam to address continued complaints of insomnia. On or about July 22, 2019, Respondent added the antidepressant bupropion extended release. The records do not contain any notation that the CURES[6] database was consulted prior to prescribing. The final visit occurred in or around September 2019.

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[2] Events occurring outside the statute of limitations period are described for background purposes only.

[3] Patient names are redacted to protect their privacy.

[4] 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 examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances.

[5] Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list of the schedules is published in Title 21 Code of Federal Regulations §§1308.11-1308.15 and California Health and Safety Code §§11053-11059. Substances are placed in their respective schedules (I-V) based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused (Schedule I being the highest, and Schedule V being the lowest).

Hereinafter, medications that are controlled substances will be identified by their Schedule the first time they are discussed. Medications that are not identified with a "Schedule **" herein are not controlled substances.

[6] Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, IV, and V controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is

10. Respondent continued to prescribe eszopiclone and temazepam for Patient 1 from in or around December 2019 through in or around April 2020, despite no documented visits occurring during that time. Respondent was aware that Patient 1 had been prescribed Tramadol, a Schedule IV narcotic medication, in or around October 2018 by another provider, after his initial prescription for temazepam and before his subsequent prescription of temazepam in or around January 2019; however, Respondent did not note this fact in the records.

**Circumstances Related to Patient 2**

11. Patient 2 first presented to Respondent in or around 2011. Respondent treated Patient 2 for complaints of depression and anxiety. Respondent initially prescribed the antidepressants Cymbalta and Wellbutrin XL (bupropion), the atypical antipsychotic Latuda, and the Schedule IV benzodiazepine clonazepam, 2 mg twice a day. On or about July 14, 2015, Respondent added a prescription for the benzodiazepine temazepam 30 mg capsule, one capsule at bedtime as needed for sleep, thirty capsules with three refills. However, the clinical record contains no documentation of the indication for temazepam, the reason for use, consideration of alternatives, or counseling regarding temazepam in combination with clonazepam. Several subsequent medical records appear to be copied forward without modifications. On or about October 19, 2016, an additional prescription for the benzodiazepine alprazolam 1 mg tablet four times per day was entered into the record without documentation of the indication for this medication, consideration of alternatives, or documentation of counseling regarding the risk of combining alprazolam with clonazepam and temazepam. The concomitant prescribing of alprazolam, clonazepam, and temazepam was active from on or about June 3, 2019 through at least on or about April 15, 2020.

12. On or about November 17, 2016, Respondent changed Patient 2's diagnosis to "attention deficit disorder" and "bipolar II disorder" without any documentation of new symptoms that led to a change in diagnosis. At the next visit, on or about December 15, 2016, the

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committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

diagnosis was reverted to major depressive disorder without a documentation of new symptoms or objective findings supporting a change in diagnosis.

13. From on or about October 9, 2013, through on or about December 5, 2018, there was no documentation of any objective observations or mental status examination. The first such documentation in the records was on or about December 5, 2018. However, following this record the progress notes did not contain any further documentation of medications prescribed to Patient 2, medication reconciliation, or medical assessments related to the treatment being provided by Respondent. On or about December 10, 2020, the progress note contains a reference to treatment with the Schedule IV stimulant armodafinil, but there is no mention in prior notes related to it. The CURES report for Patient 2 shows that the first prescription for armodafinil was filled on or about November 3, 2020, and it was prescribed by Respondent. Patient 2's record for a visit on or about February 10, 2021, does not contain a medication list or medication reconciliation.

14. Respondent felt there was no risk to Patient 2 in his prescribing three benzodiazepines at once. The CURES report indicated that Patient 2 was receiving regular prescriptions for the Schedule II opioid hydrocodone/acetaminophen from a different physician. Respondent did not document awareness of this fact in the records and was unaware Patient 2 was on other narcotic medications. In or around 2021, Respondent replaced Patient 2's prescription of temazepam with eszopiclone, but continued clonazepam and alprazolam, along with the armodafinil, presumably to address excessive sedation caused by three sedative-hypnotic agents and hydrocodone. Respondent did not clearly document any of these changes to Patient 2's medications.

**Circumstances Related to Patient 3**

15. Patient 3 was first seen by a nurse practitioner in Respondent's office in or around 2013. Patient 3's diagnoses included attention deficit hyperactivity disorder, schizoaffective disorder, bipolar II disorder, chronic post-traumatic stress disorder, and severe recurrent depression without psychotic features. Over time, Patient 3's diagnoses were changed to include borderline and narcissistic personality disorders, unspecified mood disorder and unspecified anxiety disorder, and some of the prior diagnoses were dropped from the records.

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16. After in or around August 2014, Patient 3 was seen by Respondent. He treated Patient 3 with Adderall, a Schedule II stimulant, the antipsychotic Abilify, Cymbalta, and clonazepam. From in or around 2014 through in or around 2017, she was also treated with the Schedule II psychostimulant Ritalin (methylphenidate). On or about September 12, 2017, Respondent documented that Patient 3 was overusing prescription Adderall and running out early, and that Patient 3 felt unable to control her use of Adderall. For a few months thereafter, Respondent prescribed armodafinil as a substitute for other psychostimulants. On or about February 19, 2018, Ritalin was restarted despite Patient 3's difficulty controlling her use of stimulant medications. On or about May 10, 2019, Adderall was restarted, but later discontinued as she was again unable to control her use. After in or around 2020, Respondent's progress notes did not contain medication lists or medication reconciliation and Patient 3's complaints were vaguely documented and focused on external stressors. The notes indicated that medications were continued without identification of which medications were being used, or any targeted symptoms and indications for their continued use.

17. On or about June 5, 2020, Respondent documented that Patient 3 had suicidal urges and had considered self-referral to the emergency room, though she indicated that she was no longer suicidal. The progress note does not contain any information about a suicide risk assessment or consideration of changes in management given Patient 3's apparently worsening clinical status.

18. There were also handwritten notes in the chart from on or about December 1, 2015 through on or about June 5, 2020, which contain brief notes about Patient 3's report and lists of medications. The final handwritten note indicates Patient 3's medications included armodafinil 450 mg per day, Ritalin 20 mg, four times a day, Cymbalta 120 mg daily, and Wellbutrin XL 450 mg daily. The only CURES report in Patient 3's medical record was dated on or about November 2, 2021, covering the period of on or about November 2, 2020, through on or about November 2, 2021, when a nurse practitioner was prescribing for Patient 3 instead of Respondent.

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**Circumstances Related to Patient 4**

19. Respondent saw Patient 4 on or about June 16, 2020. Patient 4 reported to Respondent that he wanted to try to stop his bupropion and clonidine (a medication commonly used for anxiety without the use of controlled substances). Patient 4 had diagnoses of depression, opioid use disorder, panic disorder, and a sleep disorder. Respondent adjusted Patient 4's treatment plan to discontinue bupropion and clonidine and reflected treatment for Patient 4 with hydroxyzine (an anxiety medication), gabapentin (an anxiety medication), Suboxone (Schedule III opioid receptor partial agonist commonly used for opioid use disorder), Pristiq, and amitriptyline (an antidepressant).

20. On or about January 19, 2022, Respondent documented that Patient 4 reported doing well. Despite the visit being telephonic, Respondent's notes included comments about Patient 4's appearance. The mental status exam noted appropriate attitude, speech, mood, thought content, and cognition. Patient 4 denied side effects from his medication. Respondent's diagnoses of Patient 4 were of depression and panic disorder, but fails to include a diagnosis of opioid use disorder. The medication list for Patient 4 included hydroxyzine (an anxiety medication), clonidine, Suboxone, and amitriptyline.

21. On or about April 19, 2022, Respondent documented that Patient 4 was doing well, but experiencing nightmares. The mental status exam noted appropriate attitude, speech, and mood, but failed to document Patient 4's thought content and thought process. Patient 4 had diagnoses of depression, panic disorder, and opioid use disorder. The medication list was unchanged from the prior visit.

22. On or about July 19, 2022, Respondent saw Patient 4, who reported that he was doing well and that his medications worked well. The mental status exam noted appropriate attitude, thought process, speech, thought content, and mood. The diagnoses and medication list were unchanged from the prior visit. Respondent discontinued Patient 4's prescription of Suboxone at this visit. However, Respondent's records fail to mention that another provider began prescribing it to Patient 4.

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23. On or about December 15, 2022, Respondent noted that Patient 4's primary care physician had started prescribing the Suboxone and the hydroxyzine. The mental status exam noted appropriate attitude, thought process, and speech, but failed to reflect Patient 4's thought content. The diagnoses were unchanged. Respondent's treatment plan mentioned a refill for amitriptyline, which appeared to be the only medication he was then prescribing for Patient 4.

**Circumstances Related to Patient 5**

24. On or about June 10, 2020, Respondent saw Patient 5 and noted Patient 5 was experiencing low mood, chronic pain, and existential concerns. Respondent's diagnoses of Patient 5 included persistent depressive (dysthymic) disorder and obsessive-compulsive disorder. Respondent's treatment plan was noted as unchanged and the medication list included duloxetine (an antidepressant that also has efficacy in treating chronic pain).

25. On or about November 18, 2020, Respondent saw Patient 5, who reported doing ok, but having some health anxiety. The mental status exam noted appropriate attitude with some anxiety, but failed to document a mental status exam review of Patient 5's thought content and thought process. The diagnosis, medication list, and treatment plan were unchanged from the prior visit.

26. Between February 16, 2022, and December 14, 2022, Respondent saw Patient 5 eight times. His diagnosis, treatment plan, and medication list remained unchanged during this period. On each visit, Respondent's notes documented a mental status exam. However, Respondent's notes failed to include a mental status exam review of Patient 5's thought content and mood on February 16, 2022, April 13, 2022, and August 10, 2022.

27. Respondent's note for Patient 5's visit on November 16, 2022, mentioned alprazolam, but did not provide context or documentation of the dose and indication for the medication, which was not discussed or included in the treatment plan prior to this visit. There is no diagnosis in Respondent's records that would indicate the need for alprazolam.

**Circumstances Related to Patient 6**

28. On or about June 25, 2020, Respondent saw Patient 6. Patient 6 reported having anxiety. The mental status exam noted appropriate appearance, speech, and thought content, but

a low and depressed mood and affect. The diagnoses included depression and anxiety disorders. Respondent's treatment plan included restarting escitalopram (an antidepressant), eszopiclone, and alprazolam. There is no justification in the record for Respondent prescribing a combination of two sedatives (eszopiclone and alprazolam), nor an explanation about why Respondent restarted the medications.

29. On or about December 15, 2022, Patient 6 saw Respondent and reported anxiety and familial stressors. Respondent noted findings on the mental status exam of appropriate attitude, but anxious mood. However, Respondent's notes failed to note findings on Patient 6's thought content or thought process. The diagnoses included an anxiety disorder. The treatment plan included adding alprazolam. Patient 6 is described as having poor medication compliance, and yet with no explanation in the records, Respondent continued to prescribe two sedative controlled substances to Patient 6.

**Circumstances Related to Patient 7**

30. On or about June 4, 2020, Patient 7 saw Respondent and reported having stress. Respondent's mental status exam findings noted appropriate appearance, attitude, speech, mood, thought content, and thought process. Patient 7 denied side effects from medications. Respondent's diagnoses included attention-deficit hyperactivity disorder, and a depressive disorder. The treatment plan was unchanged. The medication list for Patient 7 included alprazolam and paroxetine (an antidepressant), although the records provide no indication for the alprazolam. Patient 7 was also being prescribed other medications and controlled substances, including opioids, by other providers.

31. On or about February 17, 2022, Respondent saw Patient 7, who reported stressors with her husband. Respondent's mental status exam findings noted appropriate attitude and thought content, but a discouraged mood. Her diagnoses were unchanged. The treatment plan included continuing paroxetine, trazodone (an antidepressant used for insomnia), alprazolam, and Adderall. Respondent's notes on the dosing of Adderall at this visit inconsistently indicated that it is prescribed to be taken both three times per day and twice a day. However, Respondent did not actually prescribe Adderall to Patient 7 on this date. There is no identifiable justification in

Respondent's notes for prescribing the controlled substances to Patient 7, particularly considering Patient 7's older age.

32. Respondent saw Patient 7 again on or about May 18, 2022. Patient 7 continued to report stressors with her husband. Patient 7's diagnoses and treatment plan were unchanged. Respondent prescribed Adderall to Patient 7. Respondent noted findings in the mental status exam of appropriate attitude, but worried mood. However, Respondent failed to note Patient 7's thought content or thought processes.

33. On or about August 18, 2022, Patient 7 reported continued stressors with her husband to Respondent. Patient 7 mentioned having had several recent falls, but there is no indication in Respondent's notes that he considered this issue in the context of the sedatives he was prescribing to her. Patient 7 requested to switch from alprazolam to diazepam (a benzodiazepine). The stimulant Respondent previously prescribed is not listed in the treatment plan.

34. On or about October 17, 2022, Respondent saw Patient 7, who reported continued stressors with her husband, and anger. Patient 7 requested to switch back to alprazolam from diazepam. The mental status exam noted appropriate attitude, and thought content, but a low mood and some hopelessness. The diagnoses were unchanged. The treatment plan included alprazolam, paroxetine, and trazodone. The stimulant was not listed in the treatment plan.

35. In and around 2022, Respondent did not include notes in any visit with Patient 7 that another provider was regularly prescribing opioids to Patient 7.

**Circumstances Related to Patient 8**

36. On or about June 1, 2020, Patient 8 saw Respondent for continued care related to a diagnosis of severe schizophrenia.[7] Respondent's mental status exam noted appropriate attitude, mood, appearance, speech, thought content and thought process. Patient 8 denied any side effects of his medications, and the treatment plan was unchanged. Patient 8's medication list included clozapine (an antipsychotic), Viibryd (an antidepressant), clonazepam, and levothyroxine (a thyroid medication).

[7] Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality, which can be distressing for them and for their family and friends.

37. On or about January 24, 2022, Respondent saw Patient 8, who reported doing okay. The mental status exam noted appropriate attitude and some anxiety, but Respondent failed to note Patient 8's thought content and thought process. Respondent's diagnosis was unchanged and his treatment plan for Patient 8 included clozapine, Viibryd, and clonazepam.

38. On or about March 24, 2022, Respondent saw Patient 8, who reported doing well with some anxiety. The mental status exam noted appropriate attitude and speech, but again failed to note Patient 8's mood, thought content and thought process. Respondent's diagnosis and treatment plan were unchanged.

39. On or about June 27, 2022, Respondent saw Patient 8, who reported some anxiety about his family. The mental status exam noted appropriate attitude, speech, mood, and thought content, but Respondent failed to comment on Patient 8's thought process. Respondent's diagnosis and treatment plan were unchanged.

40. On or about August 26, 2022, Respondent saw Patient 8, who reported doing okay and mentioned some physical pain. The mental status exam noted appropriate attitude with some anxiety, but Respondent failed to document Patient 8's thought content or thought process. Respondent's diagnosis and treatment plan were unchanged. Though Respondent noted prescribing a 2 mg daily dose of clonazepam to Patient 8 on or about this date, he actually prescribed it at a 4 mg daily dose.

41. On or about September 30, 2022, Respondent saw Patient 8, who reported doing quite well. The mental status exam noted appropriate attitude, speech, thought process, and thought content. Respondent's diagnosis and treatment plan were unchanged.

42. On or about November 28, 2022, Respondent saw Patient 8, who reported doing reasonably well, but having some stressor with his brother. Respondent's mental status exam noted appropriate attitude, speech, and thought process, but failed to note Patient 8's thought content. Respondent's diagnosis and treatment plan were unchanged. Though Respondent noted prescribing a 2 mg daily dose of clonazepam to Patient 8 on or about this date, he actually prescribed it at a 4 mg daily dose.

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43. On or about December 22, 2022, Respondent saw Patient 8, who reported a good mood and discussed his brothers. Respondent's mental status exam noted an appropriate attitude, but failed to document Patient 8's thought content or thought process. Respondent's diagnosis and treatment plan were unchanged. Though Respondent noted prescribing a 2 mg daily dose of clonazepam to Patient 8 on or about this date, he actually prescribed it at a 4 mg daily dose.

**Circumstances Related to Patient 9**

44. On or about June 23, 2020, Patient 9 saw Respondent for continuing care related to her diagnoses of bipolar disorder, attention-deficit hyperactivity disorder, post-traumatic stress disorder, and panic disorder. Patient 9 reported anxiety at this visit and denied side effects from medications. Respondent's mental status exam noted an appropriate attitude, appearance, speech, mood, thought content, and thought process, but also some anxiety. The medication list for Patient 9 included Adderall, eszopiclone, alprazolam, lamotrigine (a mood stabilizer), and desvenlafaxine (a non-controlled antidepressant). There is no basis in Patient 9's records for Respondent's prescribing of a combination of two sedatives (eszopiclone and alprazolam), nor for prescribing a combination of two types of controlled substances (sedatives and stimulants).

45. On or about January 22, 2022, Respondent saw Patient 9, who reported anxiety and insomnia. Respondent's mental status exam noted findings of appropriate attitude and mood, but failed to document Patient 9's thought content and thought process. Respondent's diagnoses were unchanged. Respondent's treatment plan for Patient 9 included desvenlafaxine, bupropion, lamotrigine, and zolpidem (a Schedule IV hypnotic sedative). Respondent failed to note Adderall and alprazolam in Patient 9's treatment plan, although those medications are noted in both the previous and the following visits.

46. On or about March 26, 2022, Respondent saw Patient 9, who reported doing well other than some insomnia. Respondent's mental status exam findings noted appropriate attitude, speech, thought process, and mood. Respondent's diagnoses were unchanged. The treatment plan for Patient 9 included desvenlafaxine, bupropion, lamotrigine, zolpidem, Adderall, and alprazolam.

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47. On or about June 20, 2022, Respondent saw Patient 9, who reported doing all right. Respondent's mental status exam findings noted appropriate attitude, speech, and mood. Respondent's diagnoses and treatment plan are seemingly unchanged. However, the dosing of Adderall in the note was erroneously written as "Take 1 Tablet orally twice per Hour."

48. On or about September 24, 2022, Respondent saw Patient 9, who reported doing reasonably well. They discussed her medications and Patient 9 requested Vyvanse (a Schedule II stimulant) rather than Adderall. Respondent's mental status exam findings noted an appropriate attitude, but failed to document Patient 9's mood, thought content, or thought process. Respondent's diagnoses were unchanged. Respondent's treatment plan for Patient 9 included Vyvanse, lamotrigine, desvenlafaxine, bupropion, and alprazolam.

49. Though Patient 9 was regularly prescribed ketamine (a Schedule III anesthetic) and hydrocodone by another physician in or around 2022, Respondent failed to note this in his records for Patient 9 or to account for them in his treatment plan for Patient 9.

**Circumstances Related to Patient 10**

50. On or about June 20, 2020, Respondent saw Patient 10 for continuing care related to depressive disorder and attention-deficit hyperactivity disorder. Respondent's mental status exam findings noted appropriate appearance, speech, thought content, thought process as well as anxiety, yet normal mood. Respondent's treatment plan for Patient 10 was to continue her medication, which included dextroamphetamine (a Schedule II stimulant), desvenlafaxine, zolpidem, and alprazolam. There is no basis for Respondent's combined prescribing of two sedatives (zolpidem and alprazolam), nor for the combined prescribing of two controlled substances (stimulants and sedatives) for Patient 10.

51. On or about February 8, 2022, Respondent saw Patient 10, who reported feeling well but a little more depressed. Patient 10 reported that she had increased her antidepressant dose on her own, which Respondent did not discuss or note as problematic in a patient being prescribed three controlled substances. Respondent had prescribed clonazepam at the maximum recommended dose, 4 mg per day, despite prescribing it in conjunction with zolpidem, another sedative, which he had prescribed at a daily dose of 10 mg, despite the recommendation for

females to be typically treated with 5 mg. Respondent's mental status exam findings noted appropriate attitude, speech, and mood, but failed to note Patient 10's thought content or thought process. Respondent's diagnoses and medication for Patient 10 were unchanged, but listed venlafaxine (an antidepressant), dextroamphetamine, zolpidem, and clonazepam. The notation of venlafaxine appears erroneous considering the notes for visits both prior and subsequent list desvenlafaxine, not venlafaxine.[8]

52. On or about March 21, 2022, Respondent saw Patient 10, who reported worsening depression. Respondent's mental status exam findings noted appropriate attitude, but a depressed mood, and failed to comment on Patient 10's thought content and thought process. Respondent's diagnoses were unchanged. Respondent's treatment plan included desvenlafaxine, clonazepam, dextroamphetamine, and zolpidem. Respondent also referred Patient 10 to another provider for transcranial magnetic stimulation (TMS). Respondent prescribed a total dose of clonazepam of 4 mg per day for Patient 10. Respondent did not consider or address that Patient 10 was receiving the maximum recommended dose of clonazepam, a sedative, while he was simultaneously prescribing another sedative, zolpidem.

53. On or about April 30, 2022, Respondent saw Patient 10, who reported doing reasonably well and that she had an upcoming appointment for TMS. Respondent's mental status exam findings noted appropriate attitude, mood, and thought content. Respondent's diagnoses and treatment plan for Patient 10 were unchanged.

54. On or about June 25, 2022, Respondent saw Patient 10, who reported doing okay, but that she was still having some depression. She further reported that she completed a treatment course of TMS, and planned to start psychotherapy. Respondent's mental status exam findings noted an anxious and depressed mood, but failed to note Patient 10's thought content and thought process. Respondent's diagnoses and treatment plan for Patient 10 were unchanged.

55. On or about July 21, 2022, Respondent saw Patient 10, who reported doing reasonably well. Respondent's mental status exam findings noted appropriate attitude and

[8] Venlafaxine and desvenlafaxine are slightly different non-controlled antidepressants, but the latter has notably different recommended dosing.

speech, but failed to comment on Patient 10's thought content, and thought process. Respondent's diagnoses and treatment plan for Patient 10 were unchanged.

56. On or about November 5, 2022, Respondent saw Patient 10, who reported having a better mood. Though Patient 10 was regularly prescribed ketamine by another physician in or around 2022, Respondent failed to note this in his records for Patient 10 or to account for them in his treatment plan for Patient 10 until noting in this visit that Patient 10 completed ketamine treatment. Respondent's mental status exam findings noted appropriate attitude, mood, and thought content. Respondent's diagnoses and treatment plan for Patient 10 were unchanged.

57. On or about December 5, 2022, Respondent saw Patient 10, who reported doing reasonably well. Respondent's mental status exam findings noted appropriate attitude, thought process, and mood. Respondent's diagnoses and treatment plan for Patient 10 were unchanged.

**Circumstances Related to Patient 11**

58. On or about July 24, 2020, Patient 11, an older female, saw Respondent and her husband reported that she has insomnia, wanders off, and gets lost. Respondent diagnosed Patient 11 with bipolar disorder, and failed to consider whether her prescription zolpidem could be contributing to her getting lost, or whether cognitive decline would be a more appropriate diagnosis than bipolar disorder in light of her overall symptoms. Respondent's mental status exam findings noted appropriate attitude, mood, speech, thought content, and thought process, but also mentioned that she is upregulated.[9] The medications listed for Patient 11 on or about that day included Latuda, Rexulti (a medication for treatment of schizophrenia), alprazolam, and zolpidem. Respondent prescribed a dose of zolpidem of 12.5 mg per day, which is more than twice the maximum recommended dose of 5 mg for an older female. Respondent had no basis for prescribing this elevated dose of zolpidem to Patient 11.

59. On or about February 28, 2022, Respondent saw Patient 11, who reported doing quite well. Respondent's mental status exam findings noted an appropriate mood, but failed to comment on Patient 11's thought content and thought process. Respondent's diagnosis of Patient 11 was unchanged. Respondent's treatment plan for Patient 11 included alprazolam, fluoxetine,

[9] Upregulated means having an increased response to a stimulus.

zolpidem, and Latuda. Respondent had no basis for prescribing a combination of two sedatives (zolpidem and alprazolam), particularly in light of Patient 11's age. Respondent did not consider that Patient 11 was receiving more than the maximum recommended dose of zolpidem, a sedative, while simultaneously prescribing another sedative, alprazolam. Further, while Respondent's records indicated that he prescribed alprazolam for Patient 11 at a total daily dose of 1 mg, he actually prescribed it at a total daily dose of 1.5 mg.

60. On or about May 27, 2022, Respondent saw Patient 11, who reported doing reasonably well. Respondent's mental status exam findings noted appropriate attitude, speech, and thought process. Respondent's diagnosis and treatment plan for Patient 11 were unchanged.

61. On or about August 26, 2022, Respondent saw Patient 11, who reported doing quite well and that she was planning a trip. Respondent's mental status exam findings note appropriate attitude, speech, and mood, but failed to document Patient 11's thought content and thought process. Respondent's diagnosis and treatment plan for Patient 11 were unchanged.

62. On or about November 25, 2022, Respondent saw Patient 11, who again reported doing quite well. Respondent noted that Patient 11 is going to reduce her Adderall. Respondent's mental status exam findings noted appropriate attitude, speech, thought process, and mood. Aside from the new notation indicating that Patient 11 had been taking Adderall and intended to reduce her use of it, Respondent's diagnosis and treatment plan for Patient 11 were seemingly unchanged. However, Respondent did not note how much Adderall Patient 11 had been taking, or how much she intended to reduce her dose.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

63. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in act(s) and/or omission(s) amounting to gross negligence in his care and treatment of Patients 1, 2, 3, and 11. The circumstances are set forth in paragraphs 8 through 18, and 58 through 62, above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

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**Prescribing of Controlled Substances**

64. When a medical decision to use controlled substances for the treatment of a patient's condition is made, the standard of care calls for using the lowest effective dose of the controlled substances, frequently re-evaluating the need for the controlled substances, discontinuing ineffective controlled substances, and continuing prescriptions of controlled substances only after an appropriate medical evaluation of their ongoing necessity including a medical examination of the patient. Patients should also be advised of the risks of controlled substances, such as tolerance, abuse, physical or psychological dependence, and in the case of benzodiazepines, dangerous interactions with opioids, alcohol, other illicit substances, and/or other sedating medications. In the case of stimulant medications, the physician should advise the patient about the risk of abuse and dependence, and the exacerbation of other psychiatric disorders such as anxiety, mania or hypomania in the case of bipolar disorder, and psychotic symptoms.

65. Respondent prescribed temazepam 30 mg to Patient 1 on or about October 13, 2018, without any indication why the decision was made to use the 30 mg dose, rather than doses of 15 mg or 7.5 mg which are also available. Respondent subsequently failed to conduct a complete assessment of any ongoing need for temazepam, did not reconsider the diagnosis or treatment plan after the medication was unsuccessful, did not have any cogent reason for the nonstandard addition of eszopiclone to temazepam, and did not document a discussion with Patient 1 regarding the risks associated with therapy with these medications. Further, from in or around December 2019 forward, Respondent refilled both eszopiclone and temazepam without seeing Patient 1, or attempting to assess Patient 1's progress in treatment in any way. Respondent's prescription of this unusual combination of controlled substances from in or around December 2019, through in or around April 2020 to an apparently still unstable and symptomatic patient without a documented visit or medical examination constitutes gross negligence.

66. Respondent's diagnostic process in the case of Patient 3 did not follow DSM-5 guidelines and lacked a clearly adequate basis for the prescription of controlled substances. However, on or about July 17, 2017, Respondent prescribed Adderall (mixed amphetamine salts), a Schedule II controlled substance and stimulant medication, with directions to take 40 mg three

times a day, a total dose of 120 mg, which exceeds the FDA recommended maximum daily dose of 60 mg. Respondent did not discuss with Patient 3 the off-label dosing of Adderall, or the risks of utilizing this medication in connection with her previous diagnoses of bipolar II disorder or schizoaffective disorder, a psychotic disorder. Further, on or about the same day, Patient 3 was prescribed the benzodiazepine clonazepam, suggesting that the high dose of Adderall was contributing to anxiety and was therefore dosed in excess. Respondent also prescribed risperidone, an antipsychotic medication, which suggests that Patient 3 was experiencing some kind of psychotic symptom which might reasonably have been exacerbated by supra-therapeutic Adderall dosing. There was no discussion or notation of the medical decision-making process by which Respondent came to the medical opinion that this combination of medications was clinically indicated, reasonable, and appropriate. Respondent's excessive prescribing of Adderall on or about July 7, 2017, without a reasonable medical indication constitutes gross negligence.

**Prescribing Benzodiazepines**

67. While benzodiazepines are medically indicated for certain psychiatric conditions, they carry risks of abuse and dependence as reflected by their listing as Schedule IV controlled substances. Further, there is a "black box warning" for benzodiazepines regarding their concomitant use with opioids. The black box warning indicates that concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, and death. Prescribers are warned to reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate, to limit dosages and durations to the minimum required, and to follow patients for signs and symptoms of respiratory depression and sedation. The standard of care requires that when prescribing benzodiazepines, a psychiatrist should recognize and assess over-sedation arising out of that treatment. Further, the standard of care requires a psychiatrist to recognize the risk of respiratory depression resulting from combining benzodiazepines and opioid medications such as hydrocodone. Because of the risks associated with benzodiazepines, the standard of care calls for modifying the treatment plan in response to over-sedation by reducing the dose of benzodiazepines. Respondent's simultaneous

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prescribing of armodafinil with multiple benzodiazepines and the opioid medication hydrocodone to Patient 2 constitutes gross negligence.

**Suicide Risk Assessment**

68. When a patient under the care of a psychiatrist discloses suicidal urges, suicidal ideation, suicidal impulses, or suicidal behaviors, the standard of care requires the psychiatrist to complete an adequate suicide risk assessment and formulate a medical opinion about a safe level of care and appropriate treatment plan for addressing the suicidal risk. In some cases, patients with suicidal ideation should be referred to a higher level of care for stabilization in a controlled environment to minimize their risk of suicidal behavior. A comprehensive suicide risk assessment includes an assessment of the chronic risk factors for suicide, which are those that cannot be addressed directly through medical interventions such as age, gender, and diagnosis. It also is necessary to conduct an assessment of acute risk factors which are those psychosocial or symptomatic conditions that may be increasing the patient's risk of suicidal behavior in the short term. Both acute and chronic risk factors for suicide are well documented in standard literature and are a part of psychiatric training so the expectation is that psychiatrists will be readily familiar with both acute and chronic risk factors for suicide. Further, the assessment of suicide risk should include consideration of any protective factors that might be reducing the patient's risk of suicide. Synthesizing all of this information, the physician should formulate a medical opinion about the safe management of the patient's suicidal risk, and consider alternatives such as medication adjustments, more frequent follow up, initiation or intensification of psychotherapy, or psychiatric hospitalization in cases of high imminent risk.

69. On or about June 5, 2020, Respondent noted that Patient 3 was "doing okay but depressed and almost went to hospital with depression and suicidal urges but says not suicidal now but still depressed." Although Patient 3 denied present suicidal urges, Respondent did not conduct a suicide risk assessment in any level of detail. Rather, Respondent assessed that Patient 3 was "doing well" and did not change the treatment plan. The only plan listed was to continue current medications, which were not documented in the progress note, and continue outpatient follow up in a month's time. There was no further elaboration of the details of Patient 3's

suicidal urges, consideration of any risk factors or protective factors, or medical opinion formulated about Patient 3's suicide risk. Rather, Patient 3's suicidal ideation or urges did not appear to be considered as part of Respondent's medical assessment and treatment planning for Patient 3 on or about June 5, 2020. Respondent's failure to complete an adequate suicide risk assessment in the context of recent, new onset suicidal ideation or urges in Patient 3, with multiple psychiatric comorbidities, constitutes gross negligence.

**Excessive Prescribing**

70. The standard of care requires a physician not to prescribe medications that are dangerous or addicting without a medical indication. The prescription of dependence causing medications requires very careful monitoring. A physician must monitor for dangerous side effects. For patients with substance use disorders, as with all patients, a physician must perform an appropriate prior medical examination; identify a medical indication; keep accurate and complete medical records, including treatments, medications, and periodic reviews of treatment plans; and provide ongoing and follow-up medical care as appropriate and necessary.

71. On or about July 24, 2020, Respondent noted that Patient 11 had gotten lost, which is a possible sign of significant cognitive decline. At that time, Respondent was prescribing alprazolam and zolpidem for Patient 11, the latter at a dose of 12.5 mg per day, which is more than twice the recommended daily dose of 5 mg for older females. Though Respondent's records indicated that he prescribed the alprazolam at a total daily dose of 1 mg, he prescribed a total daily dose of 1.5 mg for Patient 11. In or around 2022, Respondent was still prescribing zolpidem and alprazolam at the same dosages for Patient 11. Respondent's prescribing of zolpidem at more than twice the recommended daily dose while prescribing alprazolam with the indication that Patient 11 was getting lost constitutes gross negligence.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

72. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts or omissions constituting negligence in his care and treatment of Patients 1 through 11. The circumstances are

set forth in paragraphs 8 through 71, above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

**Monitoring Metabolic Effects of Antipsychotic Pharmacotherapy**

73. Second-generation antipsychotic medications including Latuda are known to cause serious metabolic side effects including elevations in blood sugar, elevations in blood cholesterol, increased appetite and significant weight gain. The standard of care for the use of second-generation anti-psychotics is to conduct periodic laboratory monitoring of blood sugar and blood cholesterol levels. The standard of care also requires monitoring and documenting changes to the patient's appetite and weight which may be associated with the use of these medications. Respondent's failure to conduct laboratory or vital sign monitoring, refer Patient 2 to another physician who could oversee this required laboratory monitoring, or attempt to coordinate with other physicians to determine the result of this laboratory monitoring constitutes negligence.

**Excessive Prescribing**

74. The standard of care requires a physician not to prescribe medications that are dangerous or addicting without a medical indication. The prescription of dependence causing medications requires very careful monitoring. A physician must monitor for dangerous side effects. For patients with substance use disorders, as with all patients, a physician must perform an appropriate prior medical examination; identify a medical indication; keep accurate and complete medical records, including treatments, medications, and periodic reviews of treatment plans; and provide ongoing and follow-up medical care as appropriate and necessary.

75. In or around 2022, without adequate justification, Respondent prescribed a significant dose of alprazolam to Patient 7, despite her being an older adult (65 years old), and the fact that another physician was prescribing opioids for her. Respondent also prescribed two additional sedating medications (trazadone and paroxetine) for her. On or about August 18, 2022, Patient 7 reported likely side effects of having had multiple falls, which required re-assessment of the risks from taking all of those controlled medications. Respondent's failure to recognize, document, and address the risk of the two sedating medications and the benzodiazepine he was prescribing to

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Patient 7, on or about August 18, 2022, combined with his failure to acknowledge Patient 7's controlled substance medications prescribed by another provider, constitute negligence.

76. In or around 2022, Respondent prescribed three controlled substances (zolpidem, clonazepam, and a stimulant) for Patient 10. On or about February 8, 2022, Respondent noted that Patient 10 was not taking the medications as prescribed. Respondent had prescribed clonazepam at the maximum recommended dose, 4 mg per day, despite prescribing it in conjunction with zolpidem, another sedative, which he had prescribed at a daily dose of 10 mg, despite the recommendation for females to be typically treated with 5 mg. This elevated dose of sedatives Respondent prescribed to Patient 10 constitutes negligence. Additionally, Respondent failed to acknowledge and address that throughout in or around 2022, Patient 10 was also prescribed ketamine, a controlled substance with hallucinogenic properties, by another physician. Respondent's lack of acknowledgement and addressing that Patient 10 was prescribed ketamine by another physician constitutes negligence.

**Recordkeeping**

77. The standard of care requires that a complete medical record be maintained of outpatient treatment. The complete medical record would include, at a minimum, a record of subjective complaints as rendered by the patient or other informants, a record of the medications being prescribed to the patient, a record of the physician's objective observations in the form of physical examination or mental status examination findings, a record of the diagnostic impression and medical-decision making process required for the physician to formulate a medical opinion about the treatment, accurate medication lists, assessments including explanation and justification of diagnoses, and a record of the treatment plan as developed by the physician and communicated to the patient or caregiver. In instances where controlled substances are prescribed, the standard of care requires the physician to check the CURES database and incorporate the information from the database into the medical decision-making process.

78. Respondent failed to document any mental status examination of Patient 2 for approximately a five-year period ending in or around December 2018. During this period, Respondent prescribed multiple controlled substances, yet there is no record of Patient 2's

psychiatric status while being prescribed controlled substances. The records did not contain sufficient information to comprise a clear and complete record of Patient 2's outpatient treatment. Further, there were significant deficiencies in the documentation such that there was no record of the medical decision-making process around nonstandard treatment such as benzodiazepine polypharmacy, the use of stimulant or wakefulness-promoting medications during treatment with nonstandard benzodiazepine polypharmacy, or documentation that Respondent's medical decision-making process referred to the CURES report, required after on or about October 2, 2018. Respondent's failure both to document mental status examination findings and to document a complete record of the psychiatric outpatient treatment provided to Patient 2 constitutes negligence.

79. Between on or about June 7, 2019, and on or about June 5, 2020, Respondent failed to document any opinion regarding Patient 3's progress or overall diagnostic status, failed to document a medication reconciliation, and failed to document communication of a treatment plan to Patient 3. These documentation failures constitute negligence.

80. In or around 2022, Patient 4 had four visits with Respondent. Respondent's failure to document a complete or appropriate mental status exam in the notes for three of those visits and failure to include a prior diagnosis of opioid use disorder in the notes for one of those visits constitutes negligence.

81. In or around 2022, Patient 5 had eight visits with Respondent. Respondent's failure to document a complete mental status exam in the notes for three of those visits and his notation that on or about June 15, 2022, he checked CURES for Patient 5 when he had not done so constitutes negligence.

82. In or around 2022, Patient 6 had one visit with Respondent. Respondent's failure to document a complete mental status exam the one time he saw Patient 6 that year constitutes negligence.

83. In or around 2022, Patient 7 had four visits with Respondent. Respondent failed to document a complete mental status exam in one of those four visits. Respondent's documentation for the visit that occurred in or around February 2022, refers to zolpidem without appropriate

context or documentation of the dose and indication. If that medication was previously started and used as needed with a remaining supply, the record failed to explain that. Respondent's notes for visits in or around February, May, and August 2022, indicate that Respondent prescribed Adderall to Patient 7. However, Respondent actually only prescribed Adderall to Patient 7 in May 2022. If the medication was subsequently stopped or prescribed by another physician, Respondent's notes failed to explain or justify that. None of Respondent's notes for the four visits he had with Patient 7 indicate that Patient 7 was being prescribed controlled substances by another provider. Finally, none of Respondent's notes for the four visits with Patient 7 include a diagnosis that would justify his prescribing a benzodiazepine to Patient 7. These failures in Respondent's documentation of his care and treatment of Patient 7 constitute negligence.

84. In or around 2022, Patient 8 had seven visits with Respondent. Respondent failed to document a complete mental status exam at approximately six of those visits. Patient 8 suffers from severe schizophrenia requiring clozapine, an antipsychotic for treatment resistant schizophrenia. Yet most of Respondent's visits with Patient 8 do not comment on his thought content or his thought process, which are key indicators of his ongoing mental health. Furthermore, many visits noted Patient 8's ongoing anxiety, which could be a warning sign of underlying paranoia, delusion, and psychosis, and require thorough assessment and documentation of his thought content. Finally, at approximately three visits in or around 2022, Respondent documented the wrong dosage of Patient 8's clonazepam. Respondent's failure to document a complete mental status exam at approximately six of the seven visits with Patient 8 in or around 2022, and notation of the wrong dosage of clonazepam, constitute negligence.

85. In or around 2022, Patient 9 had four visits with Respondent. Respondent failed to document a complete mental status exam at approximately two of those visits. Respondent failed to document Adderall and alprazolam, both controlled substances, in Patient 9's medication list in the note for the visit on or about January 22, 2022, despite including them in the note for the following visit. Respondent failed to include zolpidem in Patient 9's medication list in the notes for the visits on or about June 20, 2022, and on or about September 24, 2022. Respondent's note for the visit on or about June 20, 2022, has an inappropriate documentation of the dosing of

Adderall. Respondent's documentation for Patient 9 does not reflect any justification for the use of three controlled medications: Adderall, alprazolam, and zolpidem. Respondent noted prescribing Adderall for Patient 9 on or about March 26, 2022, and June 20, 2022, despite only having done so on the latter date. Respondent's records for Patient 9 erroneously noted a prescription of Vyvanse on or about September 24, 2022. These failures in Respondent's documentation of his care and treatment of Patient 9 constitute negligence.

86. In or around 2022, Patient 10 had six visits with Respondent. Respondent failed to document a complete mental status exam at approximately four of those visits. Respondent's note for a visit that occurred on February 8, 2022, erroneously lists venlafaxine, rather than desvenlafaxine among Patient 10's medications. None of Respondent's records for Patient 10 document justification for Patient 10's use of three controlled medications: dextroamphetamine, clonazepam, and zolpidem. These failures in Respondent's documentation of his care and treatment of Patient 10 constitute negligence.

87. In or around 2022, Patient 11 had four visits with Respondent. Respondent failed to document a complete mental status exam for approximately two of those visits. Respondent's note for the visit on or about November 16, 2022, mentions Patient 11's use of Adderall without appropriate context or documentation of the dose and indication for its use. None of Respondent's notes for the visits in or around 2022 with Patient 11 contain justification for prescribing three controlled medications: Adderall, alprazolam, and zolpidem. Finally, Respondent noted an erroneous dose of alprazolam in Patient 11's chart. These failures in Respondent's documentation of his care and treatment of Patient 11 constitute negligence.

## THIRD CAUSE FOR DISCIPLINE

**(Incompetence)**

88. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2234, subdivision (d), of the Code, in that he demonstrated incompetence in his care and treatment of Patients 1 and 2. The circumstances are set forth in paragraphs 8 through 14, above, which are incorporated here by reference. Additional circumstances are as follows:

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89. Chronic insomnia is a frequent complaint, and practice guidelines have been developed to improve the quality of care provided to patients with that diagnosis. These guidelines emphasize the importance of psychological and behavioral interventions in the treatment of chronic insomnia and indicate that they should be first addressed through behavioral recommendations or psychotherapy. Chronic medication therapy of insomnia is discouraged. Respondent's failure to document consideration of causation and any non-pharmacological intervention regarding chronic insomnia in Patients 1 and 2 demonstrates incompetence.

90. Respondent's simultaneous prescription of three benzodiazepines to Patient 2, and unawareness of the risk of the combination of opioid and benzodiazepine medications, demonstrates a lack of knowledge of the risks of respiratory depression and sedation and thus demonstrates incompetence.

**FOURTH CAUSE FOR DISCIPLINE**

**(Recordkeeping)**

91. Respondent Dwight William Sievert, M.D., is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patients 1 through 11. The circumstances are set forth in paragraphs 8 through 62, above, which are incorporated here by reference as if fully set forth.

**DISCIPLINARY CONSIDERATIONS**

92. To determine the degree of discipline, if any, to be imposed on Respondent Dwight William Sievert, M.D., Complainant alleges that on or about October 13, 2016, in a prior disciplinary action titled *In the Matter of the Accusation Against Dwight William Sievert, M.D.* before the Medical Board of California, in Case Number 800-2014-008963, Respondent's license was revoked, with said revocation stayed, and 35 months' probation were imposed with various terms and conditions, related to Respondent's gross negligence in failing to perform an adequate suicide assessment in a psychiatric patient who subsequently committed suicide. That decision is now final and is incorporated by reference as if fully set forth herein.

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## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 47593, issued to Respondent, Dwight William Sievert, M.D.;

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

3. Ordering Respondent, Dwight William Sievert, 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; and

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

DATED: DEC 2 1 2023

JENNA JONES FOR
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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