

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

In the Matter of the First Amended
Accusation Against:

Dwight William Sievert, M.D.

Physician's and Surgeon's
Certificate No. G 47593

Respondent.

Case No.: 800-2020-067784

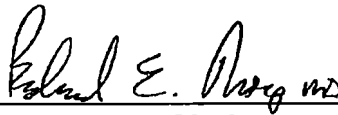
DECISION

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

1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 LYNETTE D. HECKER
Deputy Attorney General
4 State Bar No. 182198
California Department of Justice
5 2550 Mariposa Mall, Room 5090
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12
13 In the Matter of the First Amended Accusation
Against:

14 **DWIGHT WILLIAM SIEVERT, M.D.**
15 **7766 N. Palm Ave., Ste 107**
Fresno, CA 93711-5734

16 **Physician's and Surgeon's Certificate No. G**
17 **47593**

18 Respondent.

Case No. 800-2020-067784

OAH No. 2024020346

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

24 **PARTIES**

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

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

3 **CULPABILITY**

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

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

10 11. Respondent does not contest that, at an administrative hearing, Complainant could
11 establish a *prima facie* case with respect to the charges and allegations in First Amended
12 Accusation No. 800-2020-067784, a true and correct copy of which is attached hereto as "Exhibit
13 A," and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 47593 to
14 disciplinary action.

15 **RESERVATION**

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

20 **CONTINGENCY**

21 13. This stipulation shall be subject to approval by the Medical Board of California.
22 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
23 Board of California may communicate directly with the Board regarding this stipulation and
24 settlement, without notice to or participation by Respondent or his counsel. By signing the
25 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
26 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
27 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
28 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal

1 action between the parties, and the Board shall not be disqualified from further action by having
2 considered this matter.

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

6 15. Respondent agrees that if he ever petitions for early termination or modification of
7 probation, or if an accusation and/or petition to revoke probation is filed against him before the
8 Board, all of the charges and allegations contained in First Amended Accusation No. 800-2020-
9 067784 shall be deemed true, correct and fully admitted by Respondent for purposes of any such
10 proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

17 **DISCIPLINARY ORDER**

18 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate G 47593, issued to
19 Respondent DWIGHT WILLIAM SIEVERT, M.D., is revoked. However, the revocation is
20 stayed and Respondent is placed on probation for four (4) years on the following terms and
21 conditions:

22 1. **NOTIFICATION.** Within seven (7) days of the effective date of this Decision, the
23 Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief
24 of Staff or the Chief Executive Officer at every hospital where privileges or membership are
25 extended to Respondent, at any other facility where Respondent engages in the practice of
26 medicine, including all physician and *locum tenens* registries or other similar agencies, and to the
27 Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage
28 to Respondent. Respondent shall submit proof of compliance to the Board or its designee within

1 15 calendar days.

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

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

6 3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
7 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
8 limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena
9 enforcement, as applicable, in the amount of \$35,000.00 (thirty-five thousand dollars). Costs
10 shall be payable to the Medical Board of California. Failure to pay such costs shall be considered
11 a violation of probation.

12 Payment must be made in full within 30 calendar days of the effective date of the Order, or
13 by a payment plan approved by the Medical Board of California. Any and all requests for a
14 payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with
15 the payment plan shall be considered a violation of probation.

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

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

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

23 5. GENERAL PROBATION REQUIREMENTS.

24 Compliance with Probation Unit

25 Respondent shall comply with the Board's probation unit.

26 Address Changes

27 Respondent shall, at all times, keep the Board informed of Respondent's business and
28 residence addresses, email address (if available), and telephone number. Changes of such

1 addresses shall be immediately communicated in writing to the Board or its designee. Under no
2 circumstances shall a post office box serve as an address of record, except as allowed by Business
3 and Professions Code section 2021, subdivision (b).

4 Place of Practice

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

8 License Renewal

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

11 Travel or Residence Outside California

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

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

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

21 7. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
22 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
23 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
24 defined as any period of time Respondent is not practicing medicine as defined in Business and
25 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
26 patient care, clinical activity or teaching, or other activity as approved by the Board. If
27 Respondent resides in California and is considered to be in non-practice, Respondent shall
28 comply with all terms and conditions of probation. All time spent in an intensive training

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

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

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

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

14 Periods of non-practice for a Respondent residing outside of California will relieve
15 Respondent of the responsibility to comply with the probationary terms and conditions with the
16 exception of this condition and the following terms and conditions of probation: Obey All Laws;
17 General Probation Requirements; and Quarterly Declarations.

18 8. COMPLETION OF PROBATION. Respondent shall comply with all financial
19 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
20 completion of probation. This term does not include cost recovery, which is due within 30
21 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
22 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
23 shall be fully restored.

24 9. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
25 of probation is a violation of probation. If Respondent violates probation in any respect, the
26 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
27 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
28 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have

1 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
2 the matter is final.

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

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

18 12. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
19 a new license or certification, or petition for reinstatement of a license, by any other health care
20 licensing action agency in the State of California, all of the charges and allegations contained in
21 First Amended Accusation No. 800-2020-068666 shall be deemed to be true, correct, and
22 admitted by Respondent for the purpose of any Statement of Issues or any other proceeding
23 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

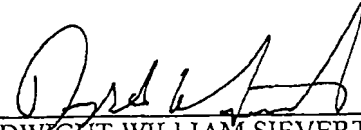
LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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1 ACCEPTANCE

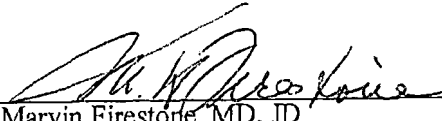
2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Marvin Firestone, MD, JD. I understand the stipulation and the
4 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
5 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
6 bound by the Decision and Order of the Medical Board of California.

7
8 DATED: 7/1/2024

9 
DWIGHT WILLIAM SIEVERT, M.D.
Respondent

10 I have read and fully discussed with Respondent Dwight William Sievert, M.D. the terms
11 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
12 Order. I approve its form and content.

13 DATED: 7/2/2024


14 
Marvin Firestone, MD, JD
Attorney for Respondent

15
16 ENDORSEMENT

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

19 DATED: 7/2/2024

20 Respectfully submitted,
21 ROB BONTA
Attorney General of California
22 STEVE DIEHL
Supervising Deputy Attorney General

23 
24 LYNETTE D. HECKER
25 Deputy Attorney General
26 Attorneys for Complainant

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1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 LYNETTE HECKER
Deputy Attorney General
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5 2550 Mariposa Mall, Room 5090
Fresno, CA 93721
6 Telephone: (559) 705-2313
Facsimile: (559) 445-5106
7 *Attorneys for Complainant*

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9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation
13 Against:

Case No. 800-2020-067784

FIRST AMENDED ACCUSATION

14 **Dwight William Sievert, M.D.**
15 **7766 N. Palm Ave., Ste. 107**
Fresno, CA 93711-5734

16 **Physician's and Surgeon's Certificate**
17 **No. G 47593,**

Respondent.

18
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20 **PARTIES**

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

24 2. On or about June 14, 1982, the Medical Board issued Physician's and Surgeon's
25 Certificate Number G 47593 to Dwight William Sievert, M.D. (Respondent). The Physician's
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27 *///*

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

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

3 JURISDICTION

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

7 4. Section 2227 of the Code states:

8 (a) A licensee whose matter has been heard by an administrative law judge of
9 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
10 Code, or whose default has been entered, and who is found guilty, or who has entered
11 into a stipulation for disciplinary action with the board, may, in accordance with the
12 provisions of this chapter:

13 (1) Have his or her license revoked upon order of the board.

14 (2) Have his or her right to practice suspended for a period not to exceed one
15 year upon order of the board.

16 (3) Be placed on probation and be required to pay the costs of probation
17 monitoring upon order of the board.

18 (4) Be publicly reprimanded by the board. The public reprimand may include a
19 requirement that the licensee complete relevant educational courses approved by the
20 board.

21 (5) Have any other action taken in relation to discipline as part of an order of
22 probation, as the board or an administrative law judge may deem proper.

23 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
24 medical review or advisory conferences, professional competency examinations,
25 continuing education activities, and cost reimbursement associated therewith that are
26 agreed to with the board and successfully completed by the licensee, or other matters
27 made confidential or privileged by existing law, is deemed public, and shall be made
28 available to the public by the board pursuant to Section 803.1.

29 STATUTORY PROVISIONS

30 5. Section 2234 of the Code, states:

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

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

36 (b) Gross negligence.

1 (c) Repeated negligent acts. To be repeated, there must be two or more
2 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.

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

5 (2) When the standard of care requires a change in the diagnosis, act, or
6 omission that constitutes the negligent act described in paragraph (1), including, but
7 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.

8 (d) Incompetence.

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

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

12 (g) The failure by a certificate holder, in the absence of good cause, to attend
13 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.

14
15 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
16 adequate and accurate records relating to the provision of services to their patients constitutes
17 unprofessional conduct.

18 **COST RECOVERY**

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

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1 **FACTUAL ALLEGATIONS²**

2 **Circumstances Related to Patient 1**

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

11 9. Patient 1 followed up in or around November 2018 and in or around January 2019,
12 and Respondent continued Patient 1’s medications. On or about February 12, 2019, Respondent
13 discontinued Pristiq, and eszopiclone, a Schedule IV sedative, was added to temazepam to
14 address continued complaints of insomnia. On or about July 22, 2019, Respondent added the
15 antidepressant bupropion extended release. The records do not contain any notation that the
16 CURES⁶ database was consulted prior to prescribing. The final visit occurred in or around
17 September 2019.

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

20 ³ Patient names are redacted to protect their privacy.

21 ⁴ Benzodiazepines are a class of agents that work on the central nervous system, acting on
22 select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain.
23 Valium, diazepam, alprazolam, and temazepam are examples of benzodiazepines. All
24 benzodiazepines are Schedule IV controlled substances.

25 ⁵ Drugs and other substances that are considered controlled substances under the
26 Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list
27 of the schedules is published in Title 21 Code of Federal Regulations §§1308.11-1308.15 and
28 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

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

7 **Circumstances Related to Patient 2**

8 11. Patient 2 first presented to Respondent in or around 2011. Respondent treated Patient
9 2 for complaints of depression and anxiety. Respondent initially prescribed the antidepressants
10 Cymbalta and Wellbutrin XL (bupropion), the atypical antipsychotic Latuda, and the Schedule IV
11 benzodiazepine clonazepam, 2 mg twice a day. On or about July 14, 2015, Respondent added a
12 prescription for the benzodiazepine temazepam 30 mg capsule, one capsule at bedtime as needed
13 for sleep, thirty capsules with three refills. However, the clinical record contains no
14 documentation of the indication for temazepam, the reason for use, consideration of alternatives,
15 or counseling regarding temazepam in combination with clonazepam. Several subsequent
16 medical records appear to be copied forward without modifications. On or about October 19,
17 2016, an additional prescription for the benzodiazepine alprazolam 1 mg tablet four times per day
18 was entered into the record without documentation of the indication for this medication,
19 consideration of alternatives, or documentation of counseling regarding the risk of combining
20 alprazolam with clonazepam and temazepam. The concomitant prescribing of alprazolam,
21 clonazepam, and temazepam was active from on or about June 3, 2019 through at least on or
22 about April 15, 2020.

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

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

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

3 13. From on or about October 9, 2013, through on or about December 5, 2018, there was
4 no documentation of any objective observations or mental status examination. The first such
5 documentation in the records was on or about December 5, 2018. However, following this record
6 the progress notes did not contain any further documentation of medications prescribed to Patient
7 2, medication reconciliation, or medical assessments related to the treatment being provided by
8 Respondent. On or about December 10, 2020, the progress note contains a reference to treatment
9 with the Schedule IV stimulant armodafinil, but there is no mention in prior notes related to it.
10 The CURES report for Patient 2 shows that the first prescription for armodafinil was filled on or
11 about November 3, 2020, and it was prescribed by Respondent. Patient 2's record for a visit on
12 or about February 10, 2021, does not contain a medication list or medication reconciliation.

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

21 **Circumstances Related to Patient 3**

22 15. Patient 3 was first seen by a nurse practitioner in Respondent's office in or around
23 2013. Patient 3's diagnoses included attention deficit hyperactivity disorder, schizoaffective
24 disorder, bipolar II disorder, chronic post-traumatic stress disorder, and severe recurrent
25 depression without psychotic features. Over time, Patient 3's diagnoses were changed to include
26 borderline and narcissistic personality disorders, unspecified mood disorder and unspecified
27 anxiety disorder, and some of the prior diagnoses were dropped from the records.

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

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

20 18. There were also handwritten notes in the chart from on or about December 1, 2015
21 through on or about June 5, 2020, which contain brief notes about Patient 3's report and lists of
22 medications. The final handwritten note indicates Patient 3's medications included armodafinil
23 450 mg per day, Ritalin 20 mg, four times a day, Cymbalta 120 mg daily, and Wellbutrin XL 450
24 mg daily. The only CURES report in Patient 3's medical record was dated on or about November
25 2, 2021, covering the period of on or about November 2, 2020, through on or about November 2,
26 2021, when a nurse practitioner was prescribing for Patient 3 instead of Respondent.

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1 **Circumstances Related to Patient 4**

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

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

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

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

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

6 **Circumstances Related to Patient 5**

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

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

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

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

26 **Circumstances Related to Patient 6**

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

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

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

13 **Circumstances Related to Patient 7**

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

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

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

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

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

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

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

20 **Circumstances Related to Patient 8**

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

27 ⁷ Schizophrenia is a serious mental illness that affects how a person thinks, feels, and
28 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.

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

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

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

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

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

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

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

6 **Circumstances Related to Patient 9**

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

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

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

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

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

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

14 **Circumstances Related to Patient 10**

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

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

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

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

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

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

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

27
28 ⁸ Venlafaxine and desvenlafaxine are slightly different non-controlled antidepressants, but
the latter has notably different recommended dosing.

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

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

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

12 **Circumstances Related to Patient 11**

13 58. On or about July 24, 2020, Patient 11, an older female, saw Respondent and her
14 husband reported that she has insomnia, wanders off, and gets lost. Respondent diagnosed Patient
15 11 with bipolar disorder, and failed to consider whether her prescription zolpidem could be
16 contributing to her getting lost, or whether cognitive decline would be a more appropriate
17 diagnosis than bipolar disorder in light of her overall symptoms. Respondent's mental status
18 exam findings noted appropriate attitude, mood, speech, thought content, and thought process, but
19 also mentioned that she is upregulated.⁹ The medications listed for Patient 11 on or about that
20 day included Latuda, Rexulti (a medication for treatment of schizophrenia), alprazolam, and
21 zolpidem. Respondent prescribed a dose of zolpidem of 12.5 mg per day, which is more than
22 twice the maximum recommended dose of 5 mg for an older female. Respondent had no basis for
23 prescribing this elevated dose of zolpidem to Patient 11.

24 59. On or about February 28, 2022, Respondent saw Patient 11, who reported doing quite
25 well. Respondent's mental status exam findings noted an appropriate mood, but failed to
26 comment on Patient 11's thought content and thought process. Respondent's diagnosis of Patient
27 11 was unchanged. Respondent's treatment plan for Patient 11 included alprazolam, fluoxetine,

28 ⁹ Upregulated means having an increased response to a stimulus.

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

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

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

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

21 **FIRST CAUSE FOR DISCIPLINE**

22 **(Gross Negligence)**

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

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1 **Prescribing of Controlled Substances**

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

13 65. Respondent prescribed temazepam 30 mg to Patient 1 on or about October 13, 2018,
14 without any indication why the decision was made to use the 30 mg dose, rather than doses of 15
15 mg or 7.5 mg which are also available. Respondent subsequently failed to conduct a complete
16 assessment of any ongoing need for temazepam, did not reconsider the diagnosis or treatment
17 plan after the medication was unsuccessful, did not have any cogent reason for the nonstandard
18 addition of eszopiclone to temazepam, and did not document a discussion with Patient 1
19 regarding the risks associated with therapy with these medications. Further, from in or around
20 December 2019 forward, Respondent refilled both eszopiclone and temazepam without seeing
21 Patient 1, or attempting to assess Patient 1's progress in treatment in any way. Respondent's
22 prescription of this unusual combination of controlled substances from in or around December
23 2019, through in or around April 2020 to an apparently still unstable and symptomatic patient
24 without a documented visit or medical examination constitutes gross negligence.

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

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

13 **Prescribing Benzodiazepines**

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

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

3 **Suicide Risk Assessment**

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

22 69. On or about June 5, 2020, Respondent noted that Patient 3 was "doing okay but
23 depressed and almost went to hospital with depression and suicidal urges but says not suicidal
24 now but still depressed." Although Patient 3 denied present suicidal urges, Respondent did not
25 conduct a suicide risk assessment in any level of detail. Rather, Respondent assessed that Patient
26 3 was "doing well" and did not change the treatment plan. The only plan listed was to continue
27 current medications, which were not documented in the progress note, and continue outpatient
28 follow up in a month's time. There was no further elaboration of the details of Patient 3's

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

7 **Excessive Prescribing**

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

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

24 **SECOND CAUSE FOR DISCIPLINE**

25 **(Repeated Negligent Acts)**

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

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

3 **Monitoring Metabolic Effects of Antipsychotic Pharmacotherapy**

4 73. Second-generation antipsychotic medications including Latuda are known to cause
5 serious metabolic side effects including elevations in blood sugar, elevations in blood cholesterol,
6 increased appetite and significant weight gain. The standard of care for the use of second-
7 generation anti-psychotics is to conduct periodic laboratory monitoring of blood sugar and blood
8 cholesterol levels. The standard of care also requires monitoring and documenting changes to the
9 patient's appetite and weight which may be associated with the use of these medications.

10 Respondent's failure to conduct laboratory or vital sign monitoring, refer Patient 2 to another
11 physician who could oversee this required laboratory monitoring, or attempt to coordinate with
12 other physicians to determine the result of this laboratory monitoring constitutes negligence.

13 **Excessive Prescribing**

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

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

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

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

14 **Recordkeeping**

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

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

1 psychiatric status while being prescribed controlled substances. The records did not contain
2 sufficient information to comprise a clear and complete record of Patient 2's outpatient treatment.
3 Further, there were significant deficiencies in the documentation such that there was no record of
4 the medical decision-making process around nonstandard treatment such as benzodiazepine
5 polypharmacy, the use of stimulant or wakefulness-promoting medications during treatment with
6 nonstandard benzodiazepine polypharmacy, or documentation that Respondent's medical
7 decision-making process referred to the CURES report, required after on or about October 2,
8 2018. Respondent's failure both to document mental status examination findings and to
9 document a complete record of the psychiatric outpatient treatment provided to Patient 2
10 constitutes negligence.

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

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

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

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

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

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

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

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

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

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

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

22 THIRD CAUSE FOR DISCIPLINE

23 (Incompetence)

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

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

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

12 **FOURTH CAUSE FOR DISCIPLINE**

13 **(Recordkeeping)**

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

18 **DISCIPLINARY CONSIDERATIONS**

19 92. To determine the degree of discipline, if any, to be imposed on Respondent Dwight
20 William Sievert, M.D., Complainant alleges that on or about October 13, 2016, in a prior
21 disciplinary action titled *In the Matter of the Accusation Against Dwight William Sievert, M.D.*
22 before the Medical Board of California, in Case Number 800-2014-008963, Respondent's license
23 was revoked, with said revocation stayed, and 35 months' probation were imposed with various
24 terms and conditions, related to Respondent's gross negligence in failing to perform an adequate
25 suicide assessment in a psychiatric patient who subsequently committed suicide. That decision is
26 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 21 2023

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

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