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

In the Matter of the Accusation Against:	
Ester Speranza Mark, M.D.	Case No.: 13-2012-224321
Physician's and Surgeon's Certificate No. A 55272	
Respondent.	

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the Decision of the above-entitled matter, and that such clerical error shall be corrected.

IT IS HEREBY ORDERED that the Decision in the above-entitled matter be and is hereby amended and corrected nunc pro tunc as of the date of entry of the Order to reflect on Page 4, Line 15, the Respondent's name is *Ester Speranza Mark, M.D.*

October 23, 2024

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

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

In the Matter of the Accusation Against: Ester Speranza Mark, M.D. Physician's and Surgeon's Certificate No. A 55272 Respondent.	Case No.: 13-2012-224321

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 23, 2024.

IT IS SO ORDERED: September 23, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
TRINA L. SAUNDERS
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Attorneys for Complainant

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

In the Matter of the Accusation Against: ESTER SPERANZA MARK, M.D. 28520 Wood Canyon Drive, Apt. 49 Aliso Viejo, California 92656 Physician's and Surgeon's Certificate No. A 55272 Respondent.	Case No. 13-2012-224321 OAH No. 2024020428 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Ester Speranza Mark, M.D. (Respondent) is represented in this proceeding by attorney Robert Keith Weinberg, whose address is 19200 Von Karman Avenue, Suite 380, Irvine, California 92612-8508

3. On May 31, 2015, the Board issued Physician's and Surgeon's Certificate No. A 55272 to Ester Speranza Mark, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in Accusation No. 13-2012-224321, and will expire on May 31, 2025, unless renewed.

JURISDICTION

4. A, Accusation in case No. 13-2012-224321 was filed before the Board, since amended, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 21, 2023. Respondent timely filed a Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 13-2012-224321 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. 13-2012-224321. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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. 13-2012-224321, if proven at a hearing, constitute cause for imposing discipline upon her 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 her 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. 13-2012-224321, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected her Physician's and Surgeon's Certificate, No. A 55272 to disciplinary action.

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

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 her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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 she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in First Amended Accusation No. 13-2012-224321 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 No. A 55272 issued to Respondent Ester Mark, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for two (2) years on the following terms and conditions:

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

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in

advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

this Decision.

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

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

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

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

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

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

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

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

7. 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.

8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $20,000 (twenty thousand dollars and zero cents). 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.

9. 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.

10. 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.

11. 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.

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

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

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

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

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

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

13. 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.

14. 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.

15. 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.

16. 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.

17. 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 Accusation No. 13-2012-224321 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert Keith Weinberg. 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: 8/6/24

ESTER SPERANZA MARK, M.D.
Respondent

I have read and fully discussed with Respondent Ester Speranza Mark, 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: 8/6/24

ROBERT KEITH WEINBERG
Attorney for Respondent

ENDORSEMENT

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

DATED: August 9, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **ESTER SPERANZA MARK, M.D.,** **28520 Wood Canyon Dr., Apt. 49** **Aliso Viejo, CA 92656-4207** **Physician's and Surgeon's Certificate No. A55272** Respondent.	Case No. 13-2012-224321 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about November 22, 1995, the Board issued Physician's and Surgeon's Certificate No. A55272 to Ester Speranza Mark, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and expires on May 31, 2023, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following sections of the Business and Professions Code (Code), Government Code, and Health

and Safety Code.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

6. Section 141 of the Code states:

(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country.

7. Section 2234 of the Code states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to

a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

9. Section 2266 of the Code states:

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

10. Section 725 of the Code states:

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

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

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

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

11. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

12. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

13. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the

following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. §§ 801, et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

14. Health and Safety Code section 11170 states:

No person shall prescribe, administer, or furnish a controlled substance for himself.

15. Section 2239 of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than

one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Division of Medical Quality[1] may order discipline of the licensee in accordance with Section 2227 or the Division of Licensing may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

16. Section 2305 of the Code states:

The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

COST RECOVERY

17. 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.

INTRODUCTION

18. This First Amended Accusation involves prescriptions for medications regulated by the Comprehensive Drug Abuse Prevention and Control Act, passed into law in 1970. Title II of this law, the Controlled Substances Act, is the legal foundation of narcotics enforcement in the United States. The Controlled Substances Act regulates the manufacture, possession, movement, and distribution of drugs in our country. The Controlled Substances Act places all drugs into one of five schedules, or classifications, and is controlled by the Department of Justice and the

[1] "Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California."

Department of Health and Human Services, including the Federal Drug Administration. In 1972, California followed the federal lead by adopting the Uniform Controlled Substance Act. (Government Code §11153 et seq.)

19. The following delineates the five schedules with examples of drugs, medications, and information about each.

A. **Schedule I Drugs**

These drugs have NO safe, accepted medical use in the United States. This schedule includes drugs such as marijuana, heroin, ecstasy, LSD, and crack cocaine. Schedule I drugs have a high tendency for abuse and have no accepted medical use. Pharmacies do not sell Schedule I drugs, and they are not available with a prescription by a physician.

B. **Schedule II Drugs**

Schedule II drugs have a high tendency for abuse, may have an accepted medical use, and can produce dependency or addiction with chronic use. Of all legal prescription medications, Schedule II controlled substances have the highest abuse potential. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs. Examples of Schedule II drugs include cocaine, opium, morphine, fentanyl, amphetamines, and methamphetamines.

Schedule II drugs may be available with a prescription by a physician, but not all pharmacies may carry them. These drugs require more stringent records and storage procedures than drugs in Schedules III and IV.

C. **Schedule III Drugs**

Schedule III drugs have less potential for abuse or addiction than drugs in the first two schedules and have a currently accepted medical use. The abuse of Schedule III drugs may lead to moderate to high psychological dependence.

Examples of Schedule III drugs include codeine, hydrocodone with acetaminophen, or anabolic steroids. Schedule III drugs may be available with a prescription, but not all pharmacies may carry them.

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D. **Schedule IV Drugs**

Schedule IV drugs have a low potential for abuse that leads only to limited physical dependence or psychological dependence relative to drugs in Schedule III. Schedule IV drugs have a currently accepted medical use and have limited addictive properties. Schedule IV drugs have the same restrictions as Schedule III drugs.

Examples of Schedule IV drugs include Xanax, valium, phenobarbital, and Rohypnol (commonly known as the "date rape" drug). These drugs may be available with a prescription, but not all pharmacies may carry them.

E. **Schedule V Drugs**

Schedule V drugs have a lower chance of abuse than Schedule IV drugs, have a currently accepted medical use in the United States, and lesser chance of dependence compared to Schedule IV drugs. This schedule includes such drugs as cough suppressants with codeine.

Schedule V drugs are regulated but generally do not require a prescription.

DEFINITIONS

20. As used herein, the terms below will have the following meanings:

"Adderall" is the brand name for a drug formulation combining amphetamine and dextroamphetamine. It is generally used to treat attention deficit hyperactivity disorder, but also has a high potential for abuse. It is defined in Health and Safety Code section 11055, subdivision (d)(1) as a Schedule II controlled substance. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestions of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. Its usual starting dose of is 0.25 to 0.5 mg three times per day (max 1.5 mg/day). It is also sold under various brand names including, alprazolam Intensol, Xanax, and Xanax XR. It is a schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and Professions code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amphetamine" is a strong central nervous system stimulant that is used in the treatment of attention deficit hyperactivity disorder, narcolepsy, and obesity. It is also commonly used as a recreational drug. It is a dangerous drug as defined in Code section 4022. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (d)(1)

"Benzodiazepines" are a class of drugs that produce central nervous system depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), clonazepam (e.g., Klonopin), diazepam (e.g., Valium), and temazepam (e.g., Restoril) are the five most prescribed, as well as the most frequently encountered benzodiazepines on the illicit market. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses.

"Ciprofloxacin" is an antibiotic medication used to treat infections. It is sold under the brand names Cetraxal®, Ciloxan®, Cipro® and Otiprio®. It is a dangerous drug as defined in Code section 4022.

"Clonazepam" is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III and IV controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from all Schedule II, III and IV controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of Schedule II, III and IV drugs. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Dextroamphetamine" is a central nervous system stimulant used to treat attention-deficit hyperactivity disorder and narcolepsy. It is sold under the brand names Dexedrine® and "Dextrostat®. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(I), and a dangerous drug as defined in Business and Professions Code section 4022.

"Dilaudid®" is a brand name for hydromorphone, an opioid pain medication used to treat moderate to severe pain. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug as designated in Health and Safety Code section 4022.

"Estradiol hemihydrate" the hemihydrate form of estradiol, the most potent, naturally produced estrogen. It is a hormone inserted in the vagina to treat dryness, itching, and burning in and around the vagina due to menopause. It is a dangerous drug as defined in the meaning of Code section 4022

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more potent than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®, Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"including" means, including, without limitation.

"Isocort®" is a brand name for an over-the-counter form of hydrocortisone. Hydrocortisone is used to treat skin irritation, allergic reactions, and other types of skin problems. It belongs to a class of drugs called corticosteroids. Isocort is an adrenal support supplement.

"Klonopin" is a brand name for clonazepam, which is a medication used to prevent and treat seizures, panic disorder, and the movement disorder known as akathisia.

"Lidocaine" is an anesthetic that works to decrease pain by temporarily numbing the area. It causes loss of feeling in the skin and surrounding tissues. It is used to prevent and to treat pain from some procedures. This medicine is also used to treat minor burns, scrapes and insect bites. It is sold as a topical cream under the brand names LMX 5®, LidaMantle®, RectiCare®, AneCream®, LMX 4 with Tegaderm®, Aspercreme with Lidocaine®, and RectaSmoothe®.

"Lorazepam" is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is sold under the brand name Ativan® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Code section 4022.

"Nandrolone" also known as 19-nortestosterone, is an androgen and anabolic steroid which is used in the form of esters such as nandrolone decanoate and nandrolone phenylpropionate. Nandrolone esters are used in the treatment of anemias, cachexia, osteoporosis, breast cancer, and for other indications is an anabolic steroid. It is a Schedule III controlled substance pursuant to Health and Safety Code 11056, subdivision (f)(19), and a dangerous drug as defined in Code section 4022.

"Norco®" is a brand name for a combination medication that contains oxycodone and acetaminophen. This combination of hydrocodone and acetaminophen is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerate. Other brand names for this combination of drugs include Hycet®, Lorcet®, Lortab®, Maxidone®, Vicodin®, Zamicet® and Zydone®.

"Oxandrolone" is an anabolic steroid. It can help patients regain weight after surgery, illness or trauma. It can help the body recover from side effects caused by long-term corticosteroid use. It can also treat bone pain caused by osteoporosis. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f)(23) and a dangerous drug as defined in Code section 2242.

"Oxycodone" is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand name, including OxyContin® (a time-release formula) and Roxicodone®. Oxycodone is also available in combination with other drugs and sold under brand names including, acetaminophen (Endocet®, Percocet®, Roxicet®, and Tylox® among others); aspirin (Endodan®,

Percodan® and Roxiprin® among others); and ibuprofen (Combunox®). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Code section 4022.

"OxyContin®" is a brand name for oxycodone.

"Paxil®" is a brand name for paroxetine, which is a Selective Serotonin Reuptake Inhibitor (SSRI) that is used to treat depression, anxiety disorders, obsessive-compulsive disorder (OCD), and premenstrual dysphoric disorder (PMDD). It is a dangerous drug as defined in Business and Professions Code section 4022.

"Phentermine" is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is sold under the brand names Lomaira® and Adipex-P®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Code section 4022.

"Pyridium®" is a brand name for phenazopyridine which is an analgesic durg used to relieve symptoms caused by urinary tract infections and other urinary problems, incldiuing urinary tract pain, burning, and urgency. It is a dangerous drug pursuant to Code section 4022.

"Soma®" is a brand name for carisoprodol. It is a muscle-relaxant and sedative. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"Stanozolol" is an androgen and anabolic steroid medication derived from dihydrotestosterone. It is used to treat anemia and hereditary angioedema. It is sold under the brand name Winstrol®. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f)(28) and a dangerous drug as defined in Code section 2242.

"Testosterone" is the primary sex hormone and anabolic steroid in males. In humans, testosterone plays a key role in the development of male reproductive tissues such as testes and prostate, as well as promoting secondary sexual characteristics such as increased muscle and bone mass, and the growth of body hair. It is a Schedule III controlled substance pursuant to Health and Safety Code 11056, subdivision (f)(30), and a dangerous drug as defined in Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. It is a centrally-acting opioid agonist and SNRI (serotonin/norepinephrine reuptake inhibitor). Tramadol is sold under various brand names, including Ultram® and ConZip®. It is a Schedule IV controlled substance pursuant to federal Controlled

Substances Act, and a dangerous drug pursuant to Code section 4022.

"Ultram®" is a brand name for tramadol.

"Vicodin®" is a brand name for a combinations drug, namely, hydrocodone/paracetamol, also known as hydrocodone/acetaminophen or hydrocodone/APAP.

"Vicoprofen®" is a brand name for a combination drug which contains a combination of hydrocodone and ibuprofen. Hydrocodone is an opioid pain medication. Vicoprofen is used short-term to relieve severe pain. It is a scheduled III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug as defined in Code section 4022.

"Vyvanse" is a brand name for lisdexamfetamine. It is a stimulant used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. It is a psychostimulant prodrug of the phenethylamine and amphetamine chemical classes. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Wellbutrin®" is a brand name for bupropion which is an antidepressant medication used to treat major depression and to assist with smoking cessation. It is also sold under various brand names including, Wellbutrin®, Zyban®, Voxra® and Budeprion®, among others. It is a dangerous drug as defined in Code section 4022.

"Xanax®" is a brand name for alprazolam.

"Zolpidem" is a sedative drug primarily used to treat insomnia. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand name Ambien® and Intermezzo®. It is a schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that she was grossly negligent in the care and treatment of her patients. The circumstances are as follows:

Patient E.M.[2] (Respondent)

22. Respondent self-prescribed the following controlled substances (to herself):

Date	Medication	#Prescribed	Physician
10/11/11	Testosterone micronized		Ester Mark

[2]The names of patients are kept confidential to protect their privacy rights, and, though known to Respondent, will be revealed to him upon receipt of a timely request for discovery.

10/11/11	Testosterone Cypionate			Ester Mark
10/11/11	Testosterone propionate micronized			Ester Mark
11/7/11	Nandrolone			Ester Mark
11/17/11	Nandrolone			Ester Mark
11/17/11	Phentermine			Ester Mark
11/17/11	Testosterone Cypionate			Ester Mark
1/6/12	Testosterone micronized			Ester Mark
1/9/12	Testosterone micronized			Ester Mark
1/10/12	Testosterone Cypionate			Ester Mark
1/10/12	Testosterone propionate micronized			Ester Mark
2/29/12	Testosterone micronized			Ester Mark
2/29/12	Testosterone Cypionate			Ester Mark
2/29/12	Nandrolone			Ester Mark
5/29/12	Testosterone micronized			Ester Mark
5/29/12	Testosterone micronized			Ester Mark
6/20/12	Nandrolone			Ester Mark
4/7/10	Zolpidem 10 mg		300	Ester Mark
4/7/10	Zolpidem 10 mg		300	Ester Mark
4/27/10	Phentermine 37.5 mg		300	Ester Mark

23. Between the dates of April 2, 2010 through July 24, 2012 Respondent prescribed, to herself, over 130 prescriptions of controlled substances. These primarily were for testosterone micronized, but also included phentermine, zolpidem, testosterone cypionate, nandrolone, and alprazolam. Respondent was prescribing controlled substances, obtaining them for herself and for distribution to patients. Respondent prescribed medication, Selegiline 5 mg cream, to patient M.P. and picked up the prescription herself at the Hallandale Pharmacy in Hallandale, Florida. Respondent used this cream on her own skin.

I. Progress Notes (Respondent)

24. The chart documents a few progress notes that appear to be written by a physician

assistant. These are cosmetic visits and include in some of the visits injections of Botox or other cosmetic medications. Other than cosmetic issues, there are no other pieces of information documented in the medical records.

II. Gross Negligence (Respondent)

25. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care and treatment of herself in that Respondent prescribed controlled substances to herself without appropriate and necessary medical emergency or justification.

Patient S.M.

26. Respondent prescribed to patient S.M. as follows:

Date	Medication	# Prescribed	Physician
8/21/11	Amphetamine 30 mg (Adderall)	30	Ester Mark
9/22/11	Amphetamine 30 mg (Adderall)	30	Ester Mark
12/4/11	Amphetamine 30 mg (Adderall)	30	Ester Mark
2/4/12	Amphetamine 30 mg (Adderall)	30	Ester Mark
3/8/12	Amphetamine 30 mg (Adderall)	60	Ester Mark
3/10/12	Amphetamine 30 mg (Adderall)	30	Ester Mark
4/7/12	Amphetamine 30 mg (Adderall)	30	Ester Mark
5/15/12	Amphetamine 30 mg (Adderall)	60	Ester Mark
6/20/12	Amphetamine 30 mg (Adderall)	60	Ester Mark

I. Progress Notes (S.M.)

27. The only progress note in the records for this patient is one dated May 20, 2013, which states that the patient had gained weight during her freshman year of college and would like to start HCG. The patient was started on HCG 500 international units per day. There is no other history, past medical history, or physical exam included. There are no other tests including laboratory, imaging, etc., in the records. There is also one sheet dated February 24, 2013. The sheet only lists medications and supplement directions however, there is no associated note including history, exam, assessment, or plan. The information on the sheet includes antibiotics:

Azithromycin and soft laxative. Also listed was a "strong anti-inflammatory," dexamethasone. There was also a cough medicine and Neosynephrine.

II. Prescribing of Controlled Substances Standard of Care. (S.M.)

28. The standard of care for prescribing controlled substances requires that the prescribing physician perform a history and physical examination, including where indicated an assessment of the pain complained of and a substance abuse history. The prescribing physician should create a treatment plan with objectives which can be evaluated as the treatment progresses. Informed consent must be obtained by the prescribing physician, including discussing the risks and benefits of the use of controlled substances. The prescribing physician must periodically review the controlled substance treatment course to determine if the treatment is effective or needs modification. Where indicated, the prescribing physician should consult with other physicians or refer the patients for additional evaluation and treatment. The prescribing physician must maintain accurate and complete records of the care and treatment provided. Except in emergencies, the prescribing physician should not prescribe controlled substances for herself or immediate family members.

29. Respondent prescribed controlled substances for this patient, her daughter. There was no documentation of this in her medical records. Prescribing for her daughter in this case violated the standard of care.

III. The Completeness and Appropriateness of the History and Examination (S.M.)

30. Standard of practice dictates that an appropriate prior exam (including sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical exam, testing, etc.) is necessary when seeing a patient and as a part of making a treatment plan. This history and exam must also be documented in the medical records. All of the components listed may not be needed for every presenting problem or visit; many diagnoses may be made without laboratory or imaging testing, but these must be considered. Performing the necessary elements and medical record documentation of these is vital.

31. An exam appropriate for the presenting complaint, or chronic diagnosis, is vital and is standard of care. For chronic problems, repeated exams are vital to better identify changes in

condition, success or failure of treatment, etc. On occasion an examination of the patient may not be necessary and the patient may be treated presumptively; however, this must be clearly documented.

32. For patients taking controlled substances, periodic updates of the history and examination are vital. If the patient is stable or under good control, the history and exam must be done at least every six months. If the patient is not stable, or not well controlled, more frequent updates need to be done. Pain requiring an advancement of dosing or change in therapy needs an updated history and exam. The written documentation must include and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues.

33. Respondent prescribed controlled substances for her daughter. There was no evidence of a history, exam, or evaluation of a possible need for the medications in her medical records.

IV. Adequacy of the Medical Records (S.M.)

34. Standard of practice dictates that documentation must be sufficient for the presenting problems or complaints, including sufficient components of history, review of symptoms, physical exam, etc. All of the components listed may not be needed for every presenting problem and visit. Many diagnoses may be made without laboratory or imaging testing, but these must be considered.

A. The documentation of the history must be sufficient to determine the diagnosis, or most probable diagnosis, or whether the condition is stable or unstable, giving guidance to the needed exam, additional tests, etc.

B. The documentation must document and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues.

C. The chart must be legible for review by trained medical professionals. There are many purposes for the medical record, including to provide clinical information regarding what was stated and done at the visit for the treating provider as a reminder, for other providers who may care for the patient in the future, for quality reviews, for billing purposes, and other purposes. It is vital that this information is legible; otherwise the information is useless and could

potentially cause harm.

35. Respondent prescribed controlled substances for her daughter. There was no documentation of a history, exam, or evaluation of a possible need for the medications in her medical records.

V. Inappropriate Prescribing of Controlled Substances to Family Members (S.M.)

36. The standard of care provides that except in emergencies, the prescribing physician should not prescribe controlled substances for herself or immediate family members.

37. Respondent prescribed controlled substances for her daughter contrary to the standard of care.

VI. Furnishing Dangerous Drugs without an Exam (S.M.)

38. Standard of practice dictates that an appropriate prior exam (including sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical exam, testing, etc.) is necessary when seeing a patient and as a part of making a treatment plan. This is necessary prior to prescribing or furnishing a dangerous drug. All controlled substances qualify as a dangerous drug.

39. This history and exam must be performed and documented in the medical records. All of the components listed may not be needed for every presenting problem or visit. Many diagnoses may be made without laboratory or imaging testing, but these must be considered and well documented. Performing the necessary elements and medical record documentation of these is vital.

40. Respondent prescribed controlled substances for her daughter. There was no evidence of an appropriate prior exam, or evaluation of a possible need for the medications in her medical records.

VII. Gross Negligence (S.M.)

41. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care for Patient S.M. as follows:

A. Respondent prescribed controlled substances to patient S.M. without appropriate and necessary medical justification.

B. The controlled substances were excessively prescribed.

C. Respondent failed to perform and document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while prescribing controlled substances to patient S.M.

D. Respondent prescribed or provided controlled substances to her daughter in the absence of emergency circumstances.

E. Respondent furnished dangerous medications without an appropriate prior exam (history and exam) of this patient.

Patient S.P.

42. Respondent prescribed to patient S.P. as follows:

Date	Medication	# Prescribed
April 2, 2012	Nandrolone	
April 2, 2012	Testosterone micronized	
June 19, 2012	Oxandrolone	
June 19, 2012	Amphetamine (Adderall)	
June 20, 2012	Nandrolone	
July 23, 2012	Stanozolol	
February 18, 2013	Oxandrolone	60
March 19, 2013	Dextroamphetamine	60
March 19, 2013	APA Oxycodone/Phytomine	60
April 22, 2013	Amphetamine 30 mg (Adderall)	60
April 25, 2013	Oxandrolone 10 mg	60
April 25, 2013	Alprazolam	60
May 17, 2013	Amphetamine 30 mg (Adderall)	60
June 1, 2013	Oxandrolone 10 mg	60
June 29, 2013	Amphetamine 30 mg (Adderall)	60
August 3, 2013	Oxandrolone 10 mg	60
August 5, 2013	Amphetamine 30 mg (Adderall)	60

August 15, 2013	Alprazolam	60
September 14, 2013	Dextroamphetamine	60
September 14, 2013	Alprazolam	60
October 17, 2013	Dextroamphetamine	120
October 17, 2013	Alprazolam	60
October 17, 2013	APA Oxycodone	60
October 17, 2013	Oxandrolone 10 mg	60
November 21, 2013	Amphetamine 30 mg (Adderall)	60
November 21, 2013	Alprazolam	60
November 22, 2013	Oxandrolone 10 mg	60
December 23, 2013	Alprazolam	60
December 23, 2013	Oxandrolone 10 mg	60
December 23, 2013	Amphetamine 30 mg (Adderall)	60
December 29, 2013	Vyvanse	30
December 29, 2013	APAP Oxycodone	90

43. Respondent had no medical record charts for patient S.P.

I. Prescribing of Controlled Substances (S.P.)

44. Respondent prescribed controlled substances for this patient, her current husband. There was no documentation of this in her medical records. Prescribing for her husband in this case violated the standard of care.

II. The Completeness and Appropriateness of the History and Examination (S.P.)

45. Respondent prescribed controlled substances for this patient, her current husband. There was no evidence of a history, exam, or evaluation of a possible need for the medications in her medical records.

III. Adequacy of the Medical Records (S.P.)

46. Respondent prescribed controlled substances for this patient, her current husband. There was no documentation of a history exam, or evaluation of a possible need for the medications in her medical records.

IV. Inappropriate Prescribing of Controlled Substances to Family Members (S.P.)

47. Respondent prescribed controlled substances for her husband. Prescribing in this case violated the standard of care.

V. Furnishing Dangerous Drugs without an Exam (S.P.)

48. Respondent prescribed controlled substances for her husband. There was no evidence of an appropriate prior exam, or evaluation of a possible need for the medications in her medical records.

VI. Gross Negligence

49. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care in the treatment of Patient S.P. as follows:

A. Respondent prescribed controlled substance prescriptions for this patient without medical justification. Respondent excessively prescribed controlled substances.

B. Respondent failed to perform an adequate history and/or physical exam, and failed to examine the patient on an ongoing basis, while providing multiple controlled substance prescriptions to the patient over a prolonged period.

C. Respondent provided or prescribed controlled substances for her husband in a the absence of emergent circumstahces.

D. Respondent furnished dangerous medications without an appropriate prior exam (history and exam) of this patient.

Patient R.M.

50. Respondent prescribed to patient R.M. as follows:

Date	Medication	# Prescribed	Physician
3/10/12	Amphetamine 30 mg (Adderall)	30	Ester Mark
10/22/09	Amphetamine 30 mg (Adderall)	180	Ester Mark
12/31/09	Dexedrine 15 mg	90	Ester Mark
1/22/10	Amphetamine 30 mg (Adderall)	180	Ester Mark
9/13/10	Amphetamine 20 mg (Adderall)	90	Ester Mark

9/16/10	Nandrolone oil		Ester Mark
11/19/10	Dilaudid 2 mg	60	Ester Mark
12/13/10	Dilaudid 2 mg	90	Ester Mark
5/5/11	Oxandrolone	60	Ester Mark
6/27/11	Amphetamine 30 mg (Adderall)	60	Ester Mark
9/28111	Oxandrolone	60	Ester Mark
10/3/11.	Amphetamine 30 mg (Adderall)	70	Ester Mark
12/4/11	Hydromorphone 2 mg	90	Ester Mark
12/6/11	Amphetamine 30 mg (Adderall)	70	Ester Mark
12/30/11	Oxandrolone	60	Ester Mark
1/26/12	Amphetamine 30 mg (Adderall)	60	Ester Mark
4/5/12	Amphetamine 30 mg (Adderall)	60	Ester Mark

51. In addition to the prescriptions above Respondent administered the following intramuscular injections: 1) on November 10, 2010, testosterone cypionate, B12, B comp, lidocaine, 2) between November 17, 2010, and November 2, 2011, nandrolone 100 mg or 150 mg with lidocaine -14 times, and 3) on December 13, 2011, testosterone cypionate.

52. Respondent diagnosed R.M. as follows: advanced coronary artery disease; status post multivessel bypass surgery; status post PTCA (stent); old inferior wall myocardial infarction; hyperlipidemia; history of splenomegaly post radiation; history of myelofibrosis. The first note in the chart dates from November 6, 2005, when Respondent saw R.M., her ex-husband. Thereafter, Respondent treated R.M. for many years during the time that they were married.

53. On or about September 16, 2010, Respondent saw patient R.M. Laboratory tests were obtained. There were some abnormal results. No history or physical was performed and/or documented.

54. On or about October 6, 2010, Respondent saw the patient again. He appeared to be feeling somewhat worse and had an increased spleen size. Vital signs were normal. 500 mL of blood were phlebotomized and the patient's vital signs were normal after the phlebotomy. A Pre-

phlebotomy and post-phlebotomy hematocrit was not performed and/or recorded.

55. On or about May 12, 2010, the patient presented to Respondent complaining of chest pain, feeling bloated, and increased abdominal girth. Anginal pains had become more frequent. He was having to use a large amount of nitroglycerin sublingual pills. Chest pain appeared to be worse when he was in the recumbent position. The patient had polycythemia vera, [3] a myeloproliferative[4] disorder which had not improved. The patient was questioned and there was an extensive review of systems and physical exam which included a large spleen palpable over 5 cm under the rib edge. The patient had chronic edema in the leg. The impression was polycythemia vera myeloproliferative disorder, worsening coronary artery disease with increasing chest pain, and additional medical problems. The plan was for a phlebotomy of 500 mL of blood since symptoms due to increased thyromegaly in blood viscosity with peripheral thrombosis could cause an ischemic event. The patient tolerated the procedure well. A pre-phlebotomy and post-phlebotomy hematocrit should have been performed and recorded. EKG and other evaluations are missing regarding the patient's chest pain.

56. There are no further progress notes in the chart for patient R.M.

I. Inappropriate Prescribing of Controlled Substances to Family Members (R.M.)

57. Respondent prescribed controlled substances for her then husband (now ex- husband), patient R.M. Prescribing in this case violated the standard of care. Based on the information and records available, appropriate and necessary medical justification for the controlled substance prescriptions written for this patient by Respondent was not present. As a result, the controlled substances were excessively prescribed.

II. Prescribing of Controlled Substances (R.M.)

58. Respondent prescribed controlled substances for this patient, her husband at the time

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[3] Polycythemia vera is a slow-growing type of blood cancer in which your bone marrow makes too many red blood cells. Polycythemia vera may also result in production of too many of the other types of blood cells — white blood cells and platelets.

[4] Myeloproliferative disorders is the name for a group of conditions that cause blood cells -- platelets, white blood cells, and red blood cells -- to grow abnormally in the bone marrow. Though myeloproliferative disorders are serious, and may pose certain health risks, people with these conditions often live for many years after diagnosis.

of treatment.

III. The Completeness and Appropriateness of the History and Examination (R.M.)

59. Respondent prescribed controlled substances for this patient, her husband at the time of treatment. Respondent failed to perform and document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while prescribing multiple controlled substance prescriptions over a prolonged period. Respondent also failed to appropriately evaluate and document the patient's chest pain and phlebotomy issues.

IV. Adequacy of the Medical Records (R.M.)

60. Respondent prescribed controlled substances for this patient, her husband at the time of treatment. There was no evidence documenting an adequate history, exam, or evaluation of a possible need for the medications in her medical records. Respondent failed to document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while providing multiple controlled substance prescriptions over a prolonged period.

V. Gross Negligence (R.M.)

61. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care in the treatment of Patient R.M. as follows:

A. Respondent provided or prescribed controlled substances for her husband (now ex-husband), in the absence of emergent circumstances. Respondent prescribed controlled substances without appropriate and necessary medical justification. The controlled substances were excessively prescribed.

B. Respondent's prescribing for her husband in this case violated the standard of care.

C. Respondent failed to take an appropriate history and document the patient's problems regarding the prescribing or providing of testosterone, oxandrolone, nandrolone, Adderall and other ADD medications, and opioids.

D. Respondent failed to perform an appropriate physical exam and document the findings relative to the prescribing of testosterone, oxandrolone, nandrolone, Adderall

and other ADD medications, and opioids. With respect to the prescription of those drugs, Respondent also failed to conduct urine drug screening, failed to utilize a controlled substance agreement, failed to document her routine inquiry regarding medication side effects, failed to perform appropriate follow up physical exams, failed to conduct and/or document risk and benefit discussions with the patient, and failed to address the patient's significant history for coronary artery disease when prescribing the controlled substances to him.

E. Respondent failed to perform and/or document an adequate history and exam to substantiate the need for the multiple controlled substances provided for patient R.M.

F. On or about May 12, 2010, Respondent saw patient R.M. for chest pain and many other symptoms. An EKG and cardiac evaluation were warranted urgently but Respondent failed to obtain them and/or document same.

G. The patient receives a number of phlebotomy procedures (drawing blood); however, Respondent failed to outline or document specific indications. Pre-phlebotomy and post-phlebotomy Hgb/Hct tests were indicated to see if the procedure was needed, and to evaluate the outcome, but Respondent failed to have them performed and/or documented.

H. Respondent's conduct set forth above constituted failures to maintain adequate and accurate records.

Patient J.G.

62. From August 8, 2011, through June 30, 2012, Respondent prescribed J.G. approximately 41 prescriptions for controlled substances. From March 1, 2013, through January 17, 2014, Respondent prescribed J.G. approximately 30 prescriptions for controlled substances. Savon #6507 was the primary pharmacy, though some of the prescriptions were filled elsewhere, such as E Compounding and Park Compounding. The medications included: zolpidem, lorazepam, testosterone micronized, and estradiol hemihydrate.

63. On or about February 17, 2011, Respondent saw patient J.G. for the first time. There

is an extensive two-page review of her past medical history, including right ovary removed-benign tumor – 1980; car accident pedestrian – 1996; benign parathyroid tumor removed – 2001; left ovary removed due to cysts – 2006; stress fracture on left leg after taking Fosamax – 2006; osteopenia; and osteoarthritis. Medications included: zolpidem 10 mg one per night; Natural progesterone 100 mg per night; bio-identical estrogen with progesterone and testosterone-vaginal cream; lorazepam 7-8 mg per day for muscle spasms and sleep. A physical exam was charted; the only portion of the physical exam that is documented is the back, extremities, and neurological which all are checked as "no." There is no written clarification thus it is impossible to know what Respondent meant by the checks in the "no" column.

64. On or about March 12, 2011, Respondent saw the patient for follow-up on laboratory results. Patient noted that her dystonia[5] feeling was worse (the patient has a past medical history of oral facial dystonia). There was no exam documented for this visit.

65. On or about April 28, 2011, the patient was seen for follow-up on her hormonal treatment. The note is not very legible. There was no exam done at this visit.

66. On or about August 11, 2011, the patient was seen for follow-up on her medications and DEXA scan. Patient had a dry cough. There was no physical exam documented. Respondent continued her medications and refilled the lorazepam.

67. J.G. was treated by Respondent numerous other times for her chronic conditions including menopause, dystonia, osteoporosis, and other chronic illnesses. Medications were refilled per the chart. On most visits no exam was documented. Laboratory tests were checked on a regular basis.

I. Prescribing of Controlled Substances (J.G.)

68. Respondent prescribed controlled substances for this patient without necessary medical justification. Controlled substances were excessively prescribed.

II. Completeness, Appropriateness, and Documentation of the History and Examination (J.G.)

69. Respondent prescribed controlled substances for this patient but there was no

[5] Dystonia is a state of abnormal muscle tone resulting in muscular spasm and abnormal posture, typically due to neurological disease or a side effect of drug therapy.

documentation of an adequate history, exam, or evaluation of a possible need for the medications in her medical records. Respondent failed to perform and document an adequate history and/or physical exam, and examine the patient on an ongoing basis, despite prescribing multiple controlled substance prescriptions over a prolonged period.

70. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard in the care and treatment of Patient J.G. as follows

A. Respondent failed to perform an appropriate history and document the patient's problems regarding the prescribing or providing the controlled substances lorazepam, zolpidem, and testosterone.

B. Respondent failed to perform an appropriate initial and/or follow up exam and legibly document the patient's problems regarding the prescribing or providing of lorazepam, zolpidem, and testosterone.

C. With regard to prescribing controlled substances to patient J.G., Respondent failed to perform or document a urine drug screening; failed to obtain or document a controlled substance agreement with this patient; failed to adequately and accurately document any explanation to the patient regarding medication side effects; failed to discuss and/or document the risks and benefits of the drug regimen with the patient, which could be significant based on her history.

Patient K.S.

71. From November 3, 2009 through July 21, 2012, Respondent prescribed K.S. approximately 38 prescriptions for controlled substances. Also, from February 22, 2013 through January 22, 2014, Respondent prescribed K.S. approximately 23 prescriptions for controlled substances. Multiple pharmacies were used to fill the medications, but primarily CVS #9762 or Medco Health. The medications included: APAP hydrocodone 325 mg / 10 mg; alprazolam; and Norco 325 / 10.

72. On or about November 3, 2009, Respondent first saw patient K.S. The chief complaint involved thyroid issues. The patient related a present history of very low energy since

having a thyroidectomy. The patient had gained substantial weight. She had tried a number of weight loss programs without benefit. The patient had suffered from depression and had tried Paxil and Wellbutrin without much help. The patient has frequent urinary tract infections. A full body scan in 2008 showed osteoarthritis in her back. She had chronic pain that is worsening. Her past surgical history consisted of thyroidectomy for Graves' disease and cancer. Her medication was Thyroid 3 gr for fatigue and she is taking iron. Her social history disclosed no smoking or drinking alcohol on her part. A review of systems revealed back pain, difficulty falling asleep, some depression, left leg popping out of joint, and no history of drug addiction. In addition, the patient's two-page review of her past medical problems listed fatigue, vaginal dryness or pain, joint pain, joint stiffness, easy bruising, anxiety, and headaches. A physical exam was documented. The patient was found to be well-developed, alert, oriented, well-nourished, and cooperative. There is a "no" under the categories of skin, head, neck, heart, and abdomen but there is no written clarification of what Respondent meant by those checks. Respondent's plan was to order medical records and prescribe Isocort 4 pellets; Lortab 10/500-one tablet twice daily, continue with thyroid and Cipro 750 twice daily for 3 days. Respondent planned to start a weight loss program when the patient returned. Some additional legible information is recorded in the plan.

73. On or about December 2, 2009, the patient returned to Respondent to follow-up on medications and blood work. There was no exam documented for this visit.

74. On or about December 17, 2009, the patient was seen for recurrence of leg pain after walking, left hip, having had symptoms off and on for 2 months. The patient complained of frequent urinary tract infections. Follow-up of laboratory testing was also sought. Respondent's plan entailed ordering an x-ray, checking urinalysis, decreasing Norco 10/320 to 3 times a day, adding Vicoprofen 10/200 once per day increasing omega-3 to 4 gm a day, continuing Isocort 4 pellets per day, and P4 100 mg at bedtime for 2 weeks before menses. Additional laboratory studies were ordered. The patient was to start vitamin D 500-1000 units per day. An additional medication was not legible.

75. On or about January 26, 2010, patient was seen for follow-up including follow-up of

her neuroscience laboratory testing. The patient was feeling much better. She had been out of Norco for approximately one week and had increased her Ultram. She said Xanax helped her anxiety. Respondent's diagnoses remained the same. Her plan included Ultram ER 100 mg for pain, Ultram 50 mg take 2 tablets 3 times a day keeping it under 400 mg per day, Norco 10/325 2 tablets twice daily for breakthrough pain, and Xanax.

76. On or about March 14, 2013, the patient phoned Respondent. The patient asked for prescription refills and Respondent filled all of them.

77. On or about August 12, 2013, the patient again sought refills on her medications. The chart notes that she is doing well except for worsening bilateral wrist pain for which she was contemplating surgery. There is no physical exam documented for this visit. Based on a letter with this same date from the patient to Respondent, this may have been a telephone call. The chart lists her current medications as the following: tramadol, Cipro, Armour Thyroid, phenazopyridine, lorazepam, alprazolam, and Norco.

78. On or about October 23, 2013, patient K.S. wrote a letter to Respondent, ordering refills on her medications and stating that she did not have any further refills. The medications requested included the following: alprazolam #270; hydrocodone/acetaminophen 10/325, #540; lorazepam 0.5 mg one tablet twice daily- #180; Cipro 750 mg one tablet twice daily, dispense 180. Respondent approved the refills but also asked to have a face to face or phone consultation scheduled.

79. On or about November 5, 2013, Respondent documented a phone conference with the patient. Respondent stated that there had been an issue with the patient's medications being refilled too soon. The patient said that due to her divorce, that her pain from her fibromyalgia was worse. She had tried different treatments through the years with very little improvement. She had been struggling with weight gain, depression, and anxiety for the past several months and that she had been on a regimen of Norco and tramadol with good response. The patient reported that she had been taking no more than 4 Norco a day and alternating with Ultram. Respondent documented that her presenting history supported a higher dose. Several times in the past she had been recommended to see a pain specialist but had not done so. The patient said that she thought

that the pain had been under better control. The patient recently, within approximately 2-1/2 months, had started using another pharmacy. In addition she had received the generic Norco instead of the brand name medication.

80. On or about November 18, 2013, Patient K.S. called Respondent on the phone. She was running out of tramadol and hydrocodone/APAP. Respondent refilled the medications.

81. On or about February 6, 2014, patient K.S. called Respondent on the phone. The patient stated that she was doing "okay." She had been dealing with chronic pain and aches and was worse at times. Her mid lower back pain was chronic due to old injuries. She was also having insomnia for several years. After an extensive note, Respondent stated that the patient needed her blood pressure taken and test with a follow-up in 6 weeks. Respondent refilled the medication.

I. Prescribing of Controlled Substances (K.S.)

82. Respondent prescribed controlled substances for this patient. The prescribing of controlled substances was done without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

II. The Completeness and Appropriateness of the History and Examination (K.S.)

83. Respondent prescribed controlled substances for this patient. Respondent failed to perform and document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while providing her with multiple controlled substance prescriptions over a prolonged period.

III. Adequacy of the Medical Records (K.S.)

84. Respondent prescribed controlled substances for this patient. Respondent failed to document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while providing multiple controlled substance prescriptions over a prolonged period.

85. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care in the treatment of Patient K.S. as follows:

A. Respondent failed to perform an appropriate history and failed to document the patient's problems regarding prescribing or providing the controlled substances - hydrocodone

/APAP and alprazolam (Xanax).

B. Respondent failed to perform an appropriate exam and failed to document the findings relative to the prescribing or providing of hydrocodone /APAP and alprazolam (Xanax).

C. In addition, with respect to prescribing controlled substances, Respondent failed to obtain prior medical records; Respondent failed to utilize urine drug screening; Respondent failed to utilize a controlled substance agreement; Respondent failed to document any inquiry by her regarding medication side effects; Respondent failed to document risk and benefit discussions with the patient, which could be significant based on his history;

D. Further, with respect to prescribing controlled substances, Respondent failed to appropriately address early refills and/or the patient using more opioids than prescribed until late in her care, i.e., by a phone call November 2013, over four years into her care of this patient.

E. During the latter part of her care of this patient, most of the Respondent's notes were of phone visits and there were no face-to-face visits between late 2012 and late 2013 in spite of Respondent continuing to prescribe controlled substances.

F. Respondent prescribed controlled substances without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

G. Respondent's medical records and documentation were inadequate and inaccurate and some of her documentation was illegible as set forth above.

Patient T.A.

86. Respondent prescribed to patient T.A. as follows:

Date	Medication	# Prescribed	Physician
4/29/13	Hydrocodone and Acet 325/10	180	Ester Mark
4/29/13	Hydrocodone and Acet 325/10	180	Ester Mark
4/29/13	Hydrocodone and Acet 325/10	180	Ester Mark
4/29/13	Hydrocodone and Acet 325/10	180	Ester Mark
4/29/13	Hydrocodone and Acet 325/10	180	Ester Mark
4/29/13	Hydrocodone and Acet 325110	180	Ester Mark

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87. Respondent had no medical record charts for patient A.T.

I. Prescribing of Controlled Substances (A.T.)

88. Respondent prescribed controlled substances for this patient. There was no documentation of this in her medical records. Prescribing for her in this case violated the standard of care. Respondent prescribed controlled substances without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

II. The Completeness and Appropriateness of the History and Examination (A.T.)

89. Respondent prescribed controlled substances for this patient. There was no evidence of a history, exam, or evaluation of a possible need for the medications in her medical records.

III. Adequacy of the Medical Records (A.T.)

90. Respondent prescribed controlled substances for this patient. There was no documentation of a history, exam, or evaluation of a possible need for the medications in her medical records.

IV. Furnishing Dangerous Drugs without an Exam (A.T.)

91. Respondent prescribed controlled substances for this patient. There was no evidence of an appropriate prior exam, or evaluation of a possible need for the medications in her medical records.

92. Respondent's conduct, as described above, constitutes unprofessional conduct and represents extreme departures from the standard of care in the treatment of Patient T.A. as follows:

A. Respondent prescribed controlled substances without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

B. Respondent failed to perform and document an adequate history and/or physical exam in spite of multiple opioid prescriptions.

C. Respondent furnished medications without an appropriate prior exam (history and exam) of this patient.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

93. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that she was repeatedly negligent in the care and treatment of her patients. The facts and circumstances alleged above in the First Cause for Discipline are incorporated here as if fully set forth and as follows:

Patient E.M.

94. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient E.M. as follows:

A. Respondent prescribed controlled substances to herself was done without appropriate and necessary medical emergency or justification.

Patient S. M.

95. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient S.M. as follows:

A. Respondent prescribed controlled substances to patient S.M. without appropriate and necessary medical justification. This is in addition to the other issues of concern with these prescriptions.

B. The controlled substances were excessively prescribed.

C. Respondent failed to perform and document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while prescribing controlled substances to patient S.M.

D. Respondent prescribed or provided controlled substances to her daughter in the absence of emergency circumstances.

E. Respondent furnished dangerous medications without an appropriate prior exam (history and exam) of this patient.

Patient S.P.

96. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient S.P. as follows:

A. Respondent prescribed controlled substance prescriptions for this patient without medical justification. Respondent excessively prescribed controlled substances.

B. Respondent failed to perform an adequate history and/or physical exam, and examine the patient on an ongoing basis, while providing multiple controlled substance prescriptions to the patient over a prolonged period.

C. Respondent failed to document an adequate history and/or physical exam, and examine the patient on an ongoing basis, while providing multiple controlled substance prescriptions over a prolonged period.

D. Respondent provided or prescribed controlled substances for her husband in the absence of emergent circumstances.

E. Respondent furnished dangerous medications without an appropriate prior exam (history and exam) of this patient.

Patient R.M.

97. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient R.M. as follows:

A. Respondent provided or prescribed controlled substances for her husband (now ex- husband), in the absence of emergent circumstances. Respondent prescribed controlled substances without appropriate and necessary medical justification. The controlled substances were excessively prescribed.

B. Respondent's prescribing for her husband in this case violated the standard of care.

C. Respondent failed to take an appropriate history and document the patient's problems regarding the prescribing or providing testosterone, oxandrolone, nandrolone, Adderall

and other ADD medications, and opioids.

D. Respondent failed to perform an appropriate physical exam and document the findings relative to the prescribing of testosterone, oxandrolone, nandrolone, Adderall and other ADD medications, and opioids. With respect to the prescription of those drugs, Respondent also failed to conduct urine drug screening, failed to utilize a controlled substance agreement, failed to document her routine inquiry regarding medication side effects, failed to perform an appropriate follow up physical exam, failed to conduct and/or document risk and benefit discussions with the patient, and failed to address the patient's significant history for coronary artery disease when prescribing the controlled substances to him.

E. Respondent failed to perform and/or document an adequate history and exam to substantiate the need for the multiple controlled substances provided for patient R.M.

F. On or about May 12, 2010, Respondent saw patient R.M. for chest pain and many other symptoms. An EKG and cardiac evaluation was warranted urgently but Respondent failed to obtain them and/or document same.

G. The patient receives a number of phlebotomy procedures (drawing blood); however, Respondent failed to outline or document specific indications. Pre-phlebotomy and post-phlebotomy Hgb/Hct tests were indicated to see if the procedure was needed, and to evaluate the outcome but Respondent failed to have them performed and/or documented.

H. Respondent's conduct set forth above constituted failures to maintain adequate and accurate records.

Patient J.G.

98. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient J.G. as follows:

A. Respondent failed to perform an appropriate history and document the patient's problems regarding the prescribing or providing the controlled substances lorazepam, zolpidem, and testosterone

B. Respondent failed to perform an appropriate initial and/or follow up exam

and legibly document the patient's problems regarding the prescribing or providing of lorazepam, zolpidem, and testosterone.

C. With regard to prescribing controlled substances to patient J.G., Respondent failed to perform or document a urine drug screening; failed to obtain or document a controlled substance agreement with this patient; failed to adequately and accurately document any explanation to the patient regarding medication side effects; failed to discuss and/or document the risks and benefits of the drug regimen with the patient, which could be significant based on her history.

Patient K.S.

99. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient K.S. as follows:

A. Respondent failed to perform an appropriate history and failed to document the patient's problems regarding prescribing or providing the controlled substances - hydrocodone /APAP and alprazolam (Xanax).

B. Respondent failed to perform an appropriate exam and failed to document the findings relative to the prescribing or providing of hydrocodone /APAP and alprazolam (Xanax).

C. In addition, with respect to prescribing controlled substances, Respondent failed to obtain prior medical records; Respondent failed to utilize urine drug screening; Respondent failed to utilize a controlled substance agreement; Respondent failed to document any inquiry by her regarding medication side effects; Respondent failed to document risk and benefit discussions with the patient, which could be significant based on his history.

D. Further, with respect to prescribing controlled substances, Respondent failed to appropriately address early refills and/or the patient using more opioids than prescribed until late in her care, i.e., by a phone call November 2013, over four years into her care of this patient.

E. During the latter part of her care of this patient, most of the Respondent's

notes were of phone visits and there were no face-to-face visits between late 2012 and late 2013 in spite of Respondent continuing to prescribe controlled substances.

F. Respondent prescribed controlled substance without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

G. Respondent's medical records and documentation were inadequate and inaccurate and some of her documentation was illegible as set forth above.

Patient T.A.

100. Respondent's conduct, as described above, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient T.A. as follows:

A. Respondent prescribed controlled substances without appropriate and necessary medical justification. Controlled substances were excessively prescribed.

B. Respondent failed to perform and document an adequate history and/or physical exam in spite of multiple opioid prescriptions.

C. Respondent furnished medications without an appropriate prior exam (history and exam) in this patient.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

101. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that he was incompetent in the care and treatment of Patients E.M.; S.M.; S.P.; R.M.; J.G.; K.S.; and T.A. The facts and circumstances alleged above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

102. Respondent is subject to disciplinary action under Code section 2266, in that she failed to maintain adequate and accurate records relating to the provision of medical services to Patients S.M.; S.P.; R.M.; J.G.; K.S.; and T.A. The fact and circumstances alleged above are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Self-Prescribing)

103. Respondent is subject to disciplinary action under Code section 2239 and Health and Safety Code section 11170 in that she prescribed to herself controlled substances. The circumstances are as follows. The facts and circumstances alleged in paragraphs 49-52 above are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

104. Respondent is subject to disciplinary action under Code section 725 in that she engaged in excessive treatment or prescribing in care and treatment of Patients E.M.; S.M.; S.P.; R.M.; J.G.; K.S.; and T.A. The facts and circumstances alleged above are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances Without a Physical Exam)

105. Respondent is subject to disciplinary action under Code section 2242 in that she prescribed controlled substances without a physical exam to Patients E.M.; S.M.; S.P.; R.M.; J.G.; K.S.; and T.A. The facts and circumstances alleged above are incorporated here as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Action by Federal Agency; Revocation of DEA License)

106. Respondent is subject to disciplinary action under sections 141 and 2305 of the Code in that Respondent's Certificate of Registration with the United States Drug Enforcement Administration (DEA) has been revoked,, restricted and limited, which would have been grounds for discipline in California as violations, of the federal or state laws that regulate dangerous drugs or controlled substances pursuant to Code section 2238, under Code section 2234, subdivision (e) in that she committed dishonest and corrupt acts, and under the Medical Practice Act. The facts and circumstances alleged above are incorporated here as if fully set forth and as follows:

107. On or about July 7, 2017, an Assistant Administrator of the DEA issued an Order to

Show Cause (OSC) to Respondent. The OSC proposed to revoke Respondent's DEA Certificate of Registration No. BM5370123, and deny her pending application pursuant to 21 U.S.C. 823(f)[6] and 824(a)(4) for the reason that Respondent's "continued registration is inconsistent with the public interest." Respondent timely requested a hearing before an Administrative Law Judge (ALJ). The matter was heard in Santa Ana, California in or around the period of January 23-24, 2018 before an ALJ.

108. On or about April 5, 2018, the ALJ issued a Recommended Decision that revoked Respondent's DEA license. On or about May 9, 2018, Respondent filed exceptions to the Recommended Decision. On or about April 30, 2021, an order adopting the ALJ's Recommended Decision (DEA Order) revoking Respondent's DEA license became effective.

109. According to the DEA Order, the Administrator found, among other things, that Respondent committed acts which render her continued registration inconsistent with the public interest. The findings included:

A. Facts. (i) On or about March 13, 2014, investigators served a warrant at Respondent's registered address. On or about June 13, 2014, investigators executed a search warrant at the same location. On both dates, investigators found a variety of controlled substances located on open shelves, on top of the office copier, and in unlocked glass cabinets[7], and there were also differences in the inventories of the controlled substances found in Respondent's office. Controlled substances were missing[8] without any record of their dispensation and Respondent was unable to account for the discrepancies through the production of required dispensing logs.

(ii) On or about March 13, 2014, while attempting to conduct a

[6] 21 U.S.C. 823, subdivision (f), provides, in pertinent part, that "[t]he Attorney General shall register an applicant to distribute controlled substances in schedule III, IV, or V, unless he determines that the issuance of such registration is inconsistent with the public interest. . . ."

[7] Moreover, none of the controlled substances found at Respondent's registered address were secured in a locked cabinet (in violation of 21 CFR 1301.75(a) and (b)).

[8] 25 Alprazolam 1 mg, 30 count bottles; 10 Clonazepam 1 mg, 30 count bottles; 3 Diethylpropion HCI 25 mg, 28 count bottles; 3 Hydrocodone 10/325 mg, 30 count bottles; 2 Hydrocodone/IBU 7.5/200 mg, 30 count bottles; 64 Phentermine 37.5 mg, 30 count bottles; 3 Temazepam 30 mg, 30 count bottles; 12 Zolpidem 10 mg, 30 count bottles; and 10 vials of various anabolic steroid and testosterone-related products.

physical inventory of the controlled substances located there, investigators were not able to locate an initial inventory or a biennial inventory. Respondent also failed to maintain complete and accurate records, including receiving records (such as DEA 222 Forms[9]), dispensing logs, or the required inventories, in violation of state and federal law.

(iii) During the search on or about June 13, 2014, investigators found prescription bottles in Respondent's possession bearing the names of at least five other individuals. The bottles were located on her office desk, in violation of the California Health and Safety Code § 11350, and 21 CFR 1306.04.

(iv) Between the time period in or around February 16, 2010 and July 13, 2015, Respondent unlawfully issued over 75 controlled substances prescriptions for other than a legitimate medical purpose or outside the usual course of professional practice. Specifically, Respondent illegally prescribed controlled substances to herself and to her current husband, S.P., in violation of the California Health and Safety Code § 11170 and 21 CFR 1306.04(a) and (b).

(v) Respondent also displayed a lack of candor during the DEA's investigation. In or around March 2014, Respondent told DEA investigators that patient files they requested "were not there," and that at least some of the missing files were at a location in Lake Forest, California, for which she did not know the address. During subsequent questioning, Respondent again stated that the charts requested by the DEA were at another location, but she did not know the location. Respondent also stated that the dispensing log that DEA requested was actually with the missing charts. In fact, the charts in question, and the dispensing log, did not exist. Also in or around June 2014, Respondent told an investigator that she did not know who owned the marijuana that was found in a suitcase in the garage of her registered location. She made this statement despite the fact that additional stashes of marijuana and large amounts of cash were discovered throughout her registered location, and she and her husband were the only individuals who lived there.

B. Storage Violations. Respondent violated 21 CFR 1301.75(b). Controlled

[9] DEA Form 222s are used to transfer or order Schedule II controlled substances. Orders for Schedule II agents will not be accepted without a Form 222.

substances in Respondent's office on two occasions were not stored in a securely locked, substantially constructed cabinet as required by 21 CFR 1301.75(b).

C. Recordkeeping and Prescribing. Applicable law required that Respondent maintain an inventory, and furthermore, that "every inventory and other records required to be kept under this part must be kept by the registrant and be available, for at least 2 years from the date of such inventory or records, for inspection and copying by authorized employees of the Administration." 21 CFR 1304.04. However, Respondent never produced an inventory as the regulations required. Moreover, Respondent showed little aptitude for coming into compliance given that she did not secure her controlled substances after repeated notifications that the storage was not adequate. She also failed to produce any patient files explaining the discrepancies in her stock of controlled substances. As to her prescribing practices, Respondent failed to provide evidence as to her rationale for issuing the prescriptions to her husband, and she failed to maintain proper documentation supporting those prescriptions by which their legitimacy could be assessed. Thus, Respondent issued these prescriptions outside the usual course of the professional practice and beneath the standard of care due to the fact that she violated state law in both not documenting a physical examination and not maintaining a medical file on her husband.

D. Pill Count. Respondent had an unexplained shortage of pills and different pill counts. For example, Temazepam is listed in a first count, at 30 mg. However, the second count for Temazepam lists both 15 mg and 30 mg, and the different dosages and include different corresponding National Drug Code (NDC) numbers. The evidence also showed that other pill overages that proved inaccurate and inadequate record keeping.

D. Respondent also failed to accept responsibility for her actions. She presented no evidence of remedial measures. And, her record keeping violations were not limited to dispensing. Moreover, the Decision noted that the ALJ appropriately considered Respondent's lack of acceptance of responsibility in his sanction recommendation.

110. The DEA Order and accompanying decision published in Federal Register Volume 86, Number 60, pages 16760 to 16783 from Docket No: 17-45 is attached hereto as **Exhibit A** and incorporated herein as if fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

111. Respondent is subject to disciplinary action under Code section 2234 in that she engaged in unprofessional conduct in care and treatment of Patients E.M.; S.M.; S.P.; R.M.; J.G.; K.S.; and T.A. and in connection with her unprofessional conduct set forth in the Eighth Cause for Discipline. The facts and circumstances alleged above are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant request 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 A55272, issued to Ester Speranza Mark, M.D.;

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

3. Ordering Ester Speranza Mark, 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: JUL 21 2023

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

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