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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: **Neal Anzai, M.D.** **Bay Psychiatric Associates** **2001 Dwight Way Room #4190** **Berkeley, CA 94704** **Physician's and Surgeon's Certificate No. G 50347,** Respondent.	Case No. 800-2022-085867 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about May 27, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number G 50347 to Neal Anzai, 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, expired on February 28, 2025, and has not been renewed.

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JURISDICTION

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

4. Section 118 of the Code states:

> (a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.
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> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.
>
> (c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

5. 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.

6. Section 2227 of the Code states:

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

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

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

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

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

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

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

STATUTORY PROVISIONS

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 no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

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. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(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 the patient's 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. Welfare and Institutions Code section 6002.10 states:

A facility licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, to provide inpatient psychiatric treatment, excluding state hospitals and county hospitals, shall establish admission procedures for minors who meet the following criteria:

(a) The minor is 14 years of age or older, and is under 18 years of age.

(b) The minor is not legally emancipated.

(c) The minor is not detained under Sections 5585.50 and 5585.53.

(d) The minor is not voluntarily committed pursuant to Section 6552.

(e) The minor has not been declared a dependent of the juvenile court pursuant to Section 300 or a ward of the court pursuant to Section 602.

(f) The minor's admitting diagnosis or condition is either of the following:

(1) A mental health disorder only. Although resistance to treatment may be a product of a mental health disorder, the resistance shall not, in itself, imply the presence of a mental health disorder or constitute evidence that the minor meets the admission criteria. A minor shall not be considered to have a mental health disorder solely for exhibiting behaviors specified under Sections 601 and 602.

(2) A mental health disorder and a substance abuse disorder.

COST RECOVERY

11. 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.

FACTUAL ALLEGATIONS

12. Patient 1[1]

Patient 1, now an 18-year-old female-to-male transgender individual[2], was first seen in the emergency department of California Pacific Medical Center on or about October 14, 2020, to treat a razor-blade laceration to his right forearm. When admitted to the emergency department, Patient 1, then a 14-year-old individual, revealed he was suicidal. Patient 1 was therefore determined to be a danger to himself, and was detained under Welfare and Institutions Code section 5150 for a 72-hour period for assessment, evaluation, and crisis intervention. That day, Patient 1 was transferred and admitted to the Alta Bates Summit Medical Center (Alta Bates) in Berkeley, California, for psychiatric treatment for various conditions including but not limited to suicidal ideation, anorexia, and major depressive disorder. The next day, on or about October 15, 2020, Patient 1's status changed from involuntary to voluntary treatment. Respondent did not obtain written consent from Patient 1 for Patient 1's voluntary admission to psychiatric treatment at Alta Bates, but instead obtained written consent from Patient 1's father, even though Patient 1 was 14-years-old at the time of admission to Alta Bates. Respondent did not document whether Patient 1 lacked the necessary capacity to sign the voluntary status admission document. Patient 1 remained at Alta Bates on a voluntary status admission until discharge on or about November 5, 2020.

13. Patient 1 was subsequently admitted to Alta Bates on two occasions: first from on or about January 22, 2021, through on or about March 29, 2021, and again on or about August 12,

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[1] For patient privacy purposes, the patients' true names have not been used in this First Amended Accusation to maintain confidentiality. The patients' identities are known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery in accordance with Government Code section 11507.6.

[2] At the time of psychiatric treatment, Patient 1 identified as a female-to-male transgendered individual. It is unknown at this time Patient 1's current gender identity, and therefore this First Amended Accusation identifies Patient 1 by his self-disclosed preferred pronouns (he/him) at the time of initial treatment by Respondent.

2021, through on or about September 7, 2021. Each of the above-described periods of treatment were supervised by Respondent as the attending psychiatrist.

14. Respondent did not maintain adequate records relating to Patient 1's voluntary inpatient psychiatric hospitalization. Over the span of approximately one year, Respondent treated Patient 1 at Alta Bates over three separate periods, totaling 118 days, on a "voluntary" basis, in a locked, acute-care inpatient psychiatric hospital. This is the highest and most restrictive level of care in psychiatry. Psychiatric hospitalization risks emotional trauma to the patient, and therefore the need for such treatment and hospitalization must be clearly documented. Respondent, however, failed to clearly document medical necessity for this level of care. As described below in paragraph 17, Respondent never performed an adequate psychiatric evaluation.

15. Moreover, Respondent did not obtain Patient 1's written consent for his voluntary psychiatric hospitalization, and instead obtained written consent from Patient 1's parents. The Lanterman-Petris-Short Act (Welfare and Institutions Code section 6002.10) requires that minors 14 years of age or older must provide written consent. Despite Patient 1 meeting the age requirement for the LPS Act, Respondent did not include any documentation that Patient 1 consented to his inpatient hospitalization, in violation of Patient 1's rights. At numerous points in the medical records, Patient 1 makes clear requests to leave the hospital. But, since Patient 1 was admitted on a voluntary status, he had the right to leave at any time. There is no documentation in the progress notes showing that the voluntary status of admission was ever provided to Patient 1, and/or that Patient 1 was informed that he was free to leave the facility at any time.

16. Patient 1's medical records from Alta Bates for the three periods of psychiatric treatment span nearly 7,000 pages due to Respondent's inadequate maintenance of adequate medical records. Respondent's medical record-keeping fails to include accurate descriptions of Patient 1's psychiatric symptoms, mood, response to treatment, side effects, stressors, functionality, and/or thoughts of harm including suicidal or homicidal ideation. Respondent's record-keeping includes multiple dictation errors that he failed to proofread or correct, leading to confusion. Respondent's medical records are incoherent, and do not comport with his duty to

provide clear, concise information relating to Patient 1's psychiatric treatment. Specifically, Respondent's medical record-keeping was deficient, and below the acceptable standard of care, in numerous categories. A review of a progress note for Patient 1 for the date of March 1, 2021, reveals the following specific deficiencies, which are repeated throughout the progress notes for other dates that Patient 1 was treated by Respondent. The progress note dated March 1, 2021, is divided into 24 separate and distinct sections, as described below:

(a) Section 1: Respondent includes irrelevant and nonsensical billing information and medical "non-sequiturs" in the clinical record, which do not have any clear applicability to the treatment of Patient 1;

(b) Section 2: Respondent includes a summary of Patient 1's previous admission to Alta Bates in October 2020. However, this section also confusingly includes information from Patient 1's admission beginning on January 21, 2021, making it difficult to understand whether the recorded information applies to the prior time period, the time period of the progress note, or a mix of both. Section 2 also includes random statements which should be included in the "Assessment/Plan" section such as "meets full criteria for PTSD and was started on Tenex but now unable to tolerate it so we'll switch to the Catapress patch;"

(c) Section 3: Respondent includes a half page of rambling, unclear descriptions of symptoms and response to treatment. This section also includes the "copy and pasted" information from the previous days' progress notes since admission (from on or about January 22, 2021 through on or about March 1, 2021). Therefore, Section 3 is nine pages long, making the progress note difficult to understand;

(d) Section 4: Respondent includes a 1.5 page summary of Patient 1's weight, although this section includes past weight recordings. Some weights and dates are underlined with no known purpose. Respondent also includes the statement "still orthostatic with pulse increase of 25-27 beats per minute and significant drop in blood pressure just going from sitting to standing," however the vital signs provided do not support this statement. The statements in this section are copied and pasted across multiple notes, with no support;

(e) Section 5: Respondent repeats multiple vital signs. There is no clear purpose why Respondent has included the vital signs again, as a full set of vital signs was provided in the previous section. Vital signs recorded in this section include blood pressure, pulse, temperature, weight, oxygen saturation. There is no date/time stamp for the vital signs and it is unclear when they were performed. In addition, the vital signs are repeated twice, although the weight recording is repeated three times;

(f) Section 6: Respondent titles this section "History" although there is a confusing repeat of reasons for the October 2020 admission along with the current hospitalization beginning in January 2021;

(g) Section 7: Respondent titles this section "Chief Complaint" but, Respondent then leaves the note blank;

(h) Section 8: Respondent titles this section HPI "History of Present Illness," but does not include a history of present illness in this section. Instead, Respondent includes nonsensical information;

(i) Section 9: This section, "Interim History," includes reasons for the October 2020 admission, but no information about the January 2021 admission;

(j) Section 10: This section, "Last Admission," is a repeated summary of the last admission, and is cut and pasted from an earlier portion of the medical record;

(k) Section 11: This section, also titled "Last Admission," is a copy and paste of every previous days' progress note subjection portion from the admission in October and November 2020, and adds an additional six pages to the March 1, 2021 progress note (even though it is verbatim copied from the earlier portion of the medical record);

(l) Section 12: This section uses an idiosyncratic acronym: "PFSH," and also is unclear as to whether the information included applies to the previous admission or otherwise. The same information included in this section is verbatim copied on pages 4188, 4225, and 4262 of the medical record;

(m) Section 13: Respondent titles this section "Review of Symptoms," but is exactly the same in every progress note for the January-March 2021 psychiatric admission. It is not clear if the ROS applies to the current or former psychiatric admission of Patient 1;

(n) Section 14: Respondent titles this section "General Appearance," and repeats the exact same information for March 1, 2021, as he includes in every date for the January-March 2021 admission;

(o) Section 15: Respondent titles this section "Musculoskeletal exam," and again, includes the same information in every progress note without making clear when the exam was conducted;

(p) Section 16: Respondent titles this section "Psychiatric Mental Status Examination," and the information included is the exact same copy/paste information for every other progress note. Moreover, the same spelling/formatting of the information included here is found in the progress notes for the October-November 2020 admission;

(q) Section 17: Respondent titles this section "Physician Suicide Risk Assessment and Attestation," and again copies and pastes all information in this section on every other progress note, making it unclear when the information is recent and/or relevant to Patient 1's condition on March 1, 2021;

(r) Section 18: Respondent titles this section "Tobacco Use" and simply states "negative." Respondent fails to include a summary of any other potential substance use other than tobacco, which is the standard of care for an adolescent psychiatric admission;

(s) Section 19: This section, "Additional Data Reviewed," includes old lab results from January 28, 2021. It is not clear whether Respondent reviewed these labs and incorporated the lab results in his treatment plan;

(t) Section 20: This section includes current medications, and is likely auto-populated from the medication orders. This section is organized and understandable, unlike the other sections in the progress note. The list of medications is not accurately reflected in Section 24, the "Plan," as summarized below;

(u) Section 21: This section, the list of "Diagnosis and Problem(s)," is the same as the first day of the psychiatric admission, and includes many diagnoses from the previous admission. It is unclear whether the issues are current on the day of the progress note, March 1, 2021;

(v) Section 22: This section, "Medical Decision Making," includes unclear scoring, undefined/unknown "severity ratings," and other meaningless information;

(w) Section 23: This section, "Assessment," is repeated in every note throughout Patient 1's January-March 2021 psychiatric admission, without any changes. The information provided is meandering, nonlinear, and does not have a logical presentation of Patient 1's symptoms or response to treatment. The information in this section is copied/pasted into each days' progress notes with identical wording, formatting, and grammar as found in every other day's "Assessment;"

(x) Section 24: This section, the "Plan," is a copy/paste of the Plan from February 9, 2021, through the end of the psychiatric admission in March 2021. The Plan is out of date, in that several medications included here are inconsistent with those on the medication list.

17. Respondent failed to perform a standard psychiatric evaluation of Patient 1 at any time during Patient 1's three periods of psychiatric treatment, spanning nearly 118 days at Alta Bates. A proper psychiatric exam would include, but not be limited to, (1) a description of the presenting problem; (2) psychiatric history recent and past including prior treating therapists, hospitalizations, medications, and interventions; (3) listing of past suicidal or violent acts; (4) history of substance abuse; (5) recording of medical treatments including past illnesses, hospitalizations, current conditions, medications, and treatments; (6) social history including family history, history of trauma; (7) education, military service, employment, economic status and spiritual involvement; (8) legal history; and (9) marriage, relationships, siblings, etc. As described above in paragraph 16, Respondent's progress notes are duplicative and vague, and do not include adequate information to show that good-faith psychiatric exams occurred on each day of Patient 1's psychiatric hospitalization.

18. Respondent likewise failed to include an adequate medical history, including a listing of all medications taken prescribed by any physician and/or over-the-counter medications, dosages, and durations. Respondent failed to conduct a "reconciliation" of medications, and/or to document an evaluation of Patient 1's laboratory testing or other screenings to ensure accurate evaluation of the psychiatric treatment. The standard of care requires a prescribing physician to establish an evidentiary basis for the prescribing decisions, and to keep adequate records of the evidence supporting the prescriptions. Moreover, numerous medications, and the nasogastric feeding tube, were ordered without documenting the need for the medications and/or risks associated with prescribing multiple medications, resulting in the prescription of medications without documented medical indication.

19. Respondent did not document a complete or useful mental status examination for each psychiatric contact with Patient 1, clarifying Patient 1's behavior, appearance, communication, speech, mood, affect, thought process, thought content, suicidal or homicidal potential, insight, judgment, and/or cognition. Respondent's documentation of contacts with Patient 1 contained confusing information and did not adequately explain the symptoms presented nor the treatment indicated. Respondent frequently used the cut and paste function, as described above in paragraph 16, to duplicate information from prior progress notes, making the medical records confusing and difficult to understand. Moreover, because the information from prior contacts was repeatedly cut/pasted into new dates of treatment, it is unclear whether Respondent accurately recorded information on each contact he had with Patient 1.

20. Respondent likewise failed to obtain ongoing informed consent from Patient 1 for treatment. Informed consent is an ongoing process which requires documentation of disclosure of information important to the patient, to ensure the patient has the capacity to make treatment decisions without coercive influence. Typically, a psychiatrist would disclose an accurate description of the diagnosis, the proposed treatment, the risks and benefits associated with the proposed treatment, relevant alternatives (including no treatment at all), and the risks and benefits of each option. Informed discussion with the patient is a crucial component of the doctor/patient

relationship, and of psychiatric treatment. There must be documentation of these discussions in the clinical record.

21. Patient 1 was prescribed multiple psychotropic medications, and there is no documentation that Respondent, or other staff, provided Patient 1 with any information regarding the psychotropic medications prescribed, including the indication, benefits and risks. There is likewise no documentation that any of this information was presented to Patient 1's parents. Respondent ordered a nasogastric tube for feeding Patient 1, a painful, dangerous, and invasive intervention. There is no documentation that Respondent ever discussed the indications, risks, benefits, or side effects of this procedure with Patient 1 or his parents. Moreover, as noted above, there is insufficient documentation to even conclude that a nasogastric tube was medically necessary.

22. Respondent prescribed excessive, redundant, unnecessary, and dangerous polypharmacy to Patient 1. Respondent's prescriptions of multiple psychotropic medications were unsupported by clearly documented therapeutic purposes in the medical records. For example, Respondent prescribed two selective serotonin reuptake inhibitor (SSRI) medications upon Patient 1's discharge on or about September 7, 2021, escitalopram and sertraline. The dosage of escitalopram, 15 mg, is considered a high dose for a 139-pound patient, as Patient 1 was at the time of discharge. Moreover, duplicating SSRI prescriptions, in combination with other serotonin activating medications (including the aripiprazole prescribed upon discharge) increases a patient's potential for developing Serotonin Syndrome. This syndrome is a life-threatening condition with serious health outcomes. Moreover, the excessive prescribing of overlapping medications increased the risk of suicide attempts in a patient with a history of suicidal ideation. Respondent also prescribed medications to treat high blood pressure despite the ongoing issues documented with hypotension, or low blood pressure. Finally, Respondent failed to consult an internist or cardiologist about the high risks associated with his prescriptions for potentially deadly cardiac conditions such as Torsades de Pointes. The combination of prescriptions given to Patient 1 risked this deadly cardiac condition, but nowhere does Respondent document that he consulted any other physicians about his decision to prescribe these

medications, or to document that he informed Patient 1 of the risks of taking multiple medications.

23. Respondent failed to order and review necessary bloodwork and other diagnostic tests required to treat and monitor medical conditions and treatments. Laboratory testing is required when treating severe anorexia, for which Respondent treated Patient 1. Lab testing would be required to monitor for electrolyte imbalances, "refeeding" syndrome which can occur with severely malnourished patients like Patient 1, cardiovascular issues, vitamin and mineral deficiencies, liver and kidney function, anemia and blood cell abnormalities, endocrine abnormalities, bone health, blood glucose regulation, monitoring of medication side effects, and monitoring via x-ray the proper positioning of the nasogastric tube to ensure placement in the stomach. It does not appear that Respondent completed any of the required diagnostic tests for Patient 1's conditions, and failed to order and/or review the required blood work and diagnostic tests to monitor Patient 1's response to treatment.

24. Respondent failed to consult and collaborate with other physicians relating to Patient 1's care, despite the need to do so. Patient 1 suffered from severe anorexia and may have been suffering from a number of medical complications. There is no indication that Respondent ever consulted with a cardiologist, internist, or other physician to address Patient 1's complex medical condition.

25. Respondent failed to document whether he had a chaperone in the interview room, or whether he conducted the interviews with Patient 1 in full view of other staff. The presence of a chaperone reflects the standard of care to prioritize patient safety, enhance trust, provide dignity and comfort, and to maintain appropriate therapeutic boundaries. Here, Respondent failed to document whether he used a chaperone at any point during treatment of Patient 1 over the course of 118 days.

26. On or about February 8, 2021, at 0925, Patient 1 was placed in physical restraints upon Respondent's order. But, at no point in the medical records does Respondent document the necessary elements involved in ordering physical restraints of a patient, including a timely assessment, medical justification, monitoring, reassessment, informed consent, and non-punitive

use. On the date that physical restraints were ordered, ostensibly for placement of a nasogastric tube, Patient 1's vital signs showed a normal weight and did not indicate the necessity for the invasive tube placement. Moreover, there was no documentation that Patient 1 was a danger to himself or others requiring restraints. It appears from the records that Respondent ordered the restraints as a punitive measure because Patient 1 had removed the medically unnecessary nasogastric tube.

27. Patient 2

Patient 2, now a 22-year-old female, was admitted to Alta Bates on eight occasions for psychiatric treatment for anorexia, depression, and anxiety from on or about October 24, 2017, (when Patient 2 was 14-years-old) through on or about March 5, 2021, for a total of approximately 187 days of inpatient treatment. Patient 2's status throughout her inpatient hospitalization was designated as voluntary treatment. But Respondent did not obtain written consent from Patient 2 for Patient 2's multiple voluntary admissions to psychiatric treatment at Alta Bates, but instead obtained written consent from Patient 2's mother and/or father, even though Patient 2 was between 14-years-old and 18-years-old at the time of her alleged "voluntary" admissions to Alta Bates. Respondent did not document whether Patient 2 lacked the necessary capacity to sign the voluntary status admission document. Each of the above-described periods of treatment were supervised by Respondent as the attending psychiatrist.

28. Respondent did not maintain adequate records relating to Patient 2's voluntary inpatient psychiatric hospitalization. This is the highest and most restrictive level of care in psychiatry. Psychiatric hospitalization risks emotional trauma to the patient, and therefore the need for such treatment and hospitalization must be clearly documented. Respondent, however, failed to clearly document medical necessity for this level of care. As described below in paragraph 31, Respondent never performed an adequate psychiatric evaluation.

29. Despite Patient 2 meeting the age requirement for the LPS Act, Respondent did not include any documentation that Patient 2 consented to her inpatient hospitalization, in violation of Patient 2's rights. At numerous points in the medical records, Patient 2 makes clear she does not want to be hospitalized. But, since Patient 2 was admitted on a voluntary status, she had the right

to leave at any time. There is no documentation in the progress notes showing that the voluntary status of admission was ever provided to Patient 2, and/or that Patient 2 was informed that she was free to leave the facility at any time. Moreover, Respondent did not document the medical necessity for inpatient psychiatric hospitalization of Patient 2.

30. Patient 2's medical records from Alta Bates for the eight periods of psychiatric treatment span over 11,000 pages due to Respondent's inadequate recordkeeping. Respondent's medical record-keeping fails to include accurate descriptions of Patient 2's psychiatric symptoms, mood, response to treatment, side effects, stressors, functionality, and/or thoughts of harm. Respondent's record-keeping includes multiple dictation errors that he failed to proofread or correct, leading to confusion. Respondent's medical records are incoherent, and do not comport with his duty to provide clear, concise information relating to Patient 2's psychiatric treatment. Specifically, Respondent's medical record-keeping was deficient, and below the acceptable standard of care, in numerous categories. A review of a sample progress note for Patient 2 for the date of February 23, 2021[3], reveals the following specific deficiencies, which are repeated throughout the progress notes for other dates that Patient 2 was treated by Respondent. The progress note dated February 23, 2021, is divided into 25 separate and distinct sections, as described below:

(a) Section 1: Respondent includes irrelevant and nonsensical billing information and medical "non-sequiturs" in the clinical record, which do not have any clear applicability to the treatment of Patient 2;

(b) Section 2: Respondent uses the copy and paste function to repeat the "subjective" portion of the hospitalization's history section;

(c) Section 3: Respondent includes a half page of rambling, unclear descriptions of symptoms and response to treatment. This section also includes the copied and pasted information from the previous days' progress notes since admission (from on or about January 6, 2021 through on or about February 23, 2021). Therefore, Section 3 is thirteen pages long, making the progress note difficult to understand;

[3] During Patient 2's eighth psychiatric hospitalization.

(d) Section 4: Respondent includes a 2-page summary of Patient 2's weight, although this section includes past weight recordings. Some weights and dates are underlined with no known purpose. Respondent also includes the statement "vital signs unstable: still severe orthostatic jump in pulse up to 43 bpm and unsteady on her feet," however the vital signs provided do not support this statement. The statements in this section are copied and pasted across multiple notes, with no support;

(e) Section 5: Respondent repeats multiple vital signs. There is no clear purpose why Respondent has included the vital signs again, as a full set of vital signs was provided in the previous section. Vital signs recorded in this section include blood pressure, pulse, temperature, weight, and oxygen saturation. There is no date/time stamp for the vital signs and it is unclear when they were performed. In addition, the vital signs are repeated twice, although the weight recording is repeated three times;

(f) Section 6: Respondent titles this section "History" although there is a confusing repeat of reasons for Patient 2's current hospitalization, and also confusingly mixes information from Patient 2's sixth psychiatric admission along with the current hospitalization;

(g) Section 7: Respondent titles this section "PFSH – Past Psychiatric/Medical/Social/Family History" although this section contains none of the information in the title. Section 7 includes nonsensical and useless personal historical information for Patient 2;

(h) Section 8: Respondent titles this section "Psychosocial History," but does not include Patient 2's psychological or social history in this section. Instead, Respondent includes nonsensical information;

(i) Section 9: This section, "Hospital Course, Last (7th) Admission," includes a 3-page long copy and paste of every previous days' progress note subjective portion from the previous admission on or about May 19, 2020, through June 1, 2020;

(j) Section 10: This section, "Hospital Course, 6th Admission," is a long and confusing summary of Patient 2's psychiatric admission from on or about November 21, 2019 through on or about December 12, 2019;

(k) Section 11: This section, titled "Fourth Hospitalization," is a long, disorganized, and confusing summary of Patient 2's admission from in or about March to April, 2019, with unknown purpose;

(l) Section 12: This section is titled "Review of Symptoms," but is exactly the same in every progress note for Patient 2's eighth psychiatric admission, and also is unclear as to whether the information included applies to the current or previous admission, or otherwise;

(m) Section 13: Respondent titles this section "General Appearance," but the information is exactly the same in every progress note for both the current and prior psychiatric admissions;

(n) Section 14: Respondent titles this section "Musculoskeletal exam," and again, the information is exactly the same in every progress note for both the current and prior psychiatric admissions;

(o) Section 15: Respondent titles this section "Psychiatric Mental Status Examination (MSE)," and again, includes the same information in every progress note without making clear when the exam was conducted. This is even more confused by the fact that the text in this section is the exact same for every progress note in the current (8^{th}) admission, as well as the prior (7^{th}) admission, including the same spelling and formatting;

(p) Section 16: Respondent titles this section "Physician Suicide Risk Assessment and Attestation," and the information included is the exact same information for every other progress note during the current admission, making it unclear whether the information is recent and relevant to the date of the progress note (2/23/21);

(q) Section 17: Respondent titles this section "Screening Measures," and again it is unclear whether the information included is current, or copied and pasted from a previous date;

(r) Section 18: This section includes a PHQ-9 score stating "positive at 21." It is unclear if this score is relevant for this admission, as it is the exact same score in all other progress notes for the current (8^{th}) admission;

(s) Section 19: This section about "tobacco use" and "alcohol use" simply states "negative." Respondent omits discussion of any other substance use (beyond alcohol and tobacco);

(t) Section 20: This section includes labs taken on or about January 12, 2021, over a month prior. It is unclear whether Respondent reviewed these labs and incorporated the results in his treatment plan;

(u) Section 21: This section includes current medications, and is likely auto-populated into the note from the medication orders. This section is organized and understandable, in contrast to the notes written by Respondent. This section includes medication dose, route, frequency, and date last administered, but the list of medications is not accurately reflected in Respondent's "Plan" section;

(v) Section 22: This section contains a list of diagnoses and problems, but remains unchanged since the first day of the 8th admission. Many of the diagnoses have resolved and are no longer relevant on the date of this progress note;

(w) Section 23: This section includes unclear scoring, undefined and/or unknown "severity" ratings and other meaningless information;

(x) Section 24: This section, the "assessment," is repeated in every note since the patient's initial admission in or about January 2021, with no changes. It is a nonlinear and confusing description of Patient 2, without discussion of progression of Patient 2 during treatment;

(y) Section 25: This section, the "Plan," includes inaccurate and repeated information from earlier progress notes. The Plan is out of date, and includes information on medications that were discontinued over a month prior. Also, there are medications on the "medication list" that are not included in the Plan.

31. Respondent failed to perform a standard psychiatric evaluation of Patient 2 at any time during Patient 2's eight periods of psychiatric treatment. As described above in paragraph 30, Respondent's progress notes are duplicative and vague, and do not include adequate

information to show that good-faith psychiatric exams occurred on each day of Patient 2's psychiatric hospitalization.

32. Respondent likewise failed to include an adequate medical history, including a listing of all medications taken prescribed by any physician and/or over-the-counter medications, dosages, and durations. Respondent failed to conduct a "reconciliation" of medications, and/or to document an evaluation of Patient 2's laboratory testing or other screenings to ensure accurate evaluation of the psychiatric treatment. The standard of care requires a prescribing physician to establish an evidentiary basis for the prescribing decisions, and to keep adequate records of the evidence supporting the prescriptions. Moreover, numerous medications, and the nasogastric feeding tube, were ordered without documenting the need for the medications and/or risks associated with prescribing multiple medications, resulting in the prescription of medications without documented medical indication.

33. Respondent likewise failed to obtain ongoing informed consent from Patient 2 for treatment. Informed consent is an ongoing process which requires documentation of disclosure of information important to the patient, to ensure the patient has the capacity to make treatment decisions without coercive influence. Typically, a psychiatrist would disclose an accurate description of the diagnosis, the proposed treatment, the risks and benefits associated with the proposed treatment, relevant alternatives (including no treatment at all), and the risks and benefits of each option. Informed discussion with the patient is a crucial component of the doctor/patient relationship, and of psychiatric treatment. There must be documentation of these discussions in the clinical record.

34. Patient 2 was prescribed multiple psychotropic medications, and there is no documentation that Respondent, or other staff, provided Patient 2 with any information regarding the psychotropic medications prescribed, including the indication, benefits and risks. There is likewise no documentation that any of this information was presented to Patient 2's parents. Respondent ordered a nasogastric tube for feeding Patient 2, a painful, dangerous, and invasive intervention. There is no documentation that Respondent ever discussed the indications, risks, benefits, or side effects of this procedure with Patient 2 or her parents. Moreover, as noted above,

there is insufficient documentation to even conclude that a nasogastric tube was medically necessary.

35. Respondent prescribed excessive, redundant, unnecessary, and dangerous polypharmacy to Patient 2. Respondent's prescriptions of multiple psychotropic medications were unsupported by clearly documented therapeutic purposes in the medical records. Respondent failed to consult an internist or cardiologist about the high risks associated with his prescriptions for potentially deadly cardiac conditions such as Torsades de Pointes. The combination of prescriptions given to Patient 2 risked this deadly cardiac condition, but nowhere does Respondent document that he consulted any other physicians about his decision to prescribe these medications, or to document that he informed Patient 2 of the risks of taking multiple medications.

36. Respondent failed to order and review necessary bloodwork and other diagnostic tests required to treat and monitor medical conditions and treatments. Laboratory testing is required when treating severe anorexia, for which Respondent treated Patient 2. Lab testing would be required to monitor for electrolyte imbalances, "refeeding" syndrome which can occur with severely malnourished patients like Patient 2, cardiovascular issues, vitamin and mineral deficiencies, liver and kidney function, anemia and blood cell abnormalities, endocrine abnormalities, bone health, blood glucose regulation, monitoring of medication side effects, and monitoring via x-ray the proper positioning of the nasogastric tube to ensure placement in the stomach. It does not appear that Respondent completed any of the required diagnostic tests for Patient 2's conditions, and failed to order and/or review the required blood work and diagnostic tests to monitor Patient 2's response to treatment.

37. Respondent failed to consult and collaborate with other physicians relating to Patient 2's care, despite the need to do so. Patient 2 suffered from severe anorexia and may have been suffering from a number of medical complications. There is no indication that Respondent ever consulted with a cardiologist, internist, or other physician to address Patient 2's complex medical condition.

38. Respondent failed to document whether he had a chaperone in the interview room, or whether he conducted the interviews with Patient 2 in full view of other staff. The presence of a chaperone reflects the standard of care to prioritize patient safety, enhance trust, provide dignity and comfort, and to maintain appropriate therapeutic boundaries. Here, Respondent failed to document whether he used a chaperone at any point during treatment of Patient 2 over the course of approximately 187 days of inpatient treatment.

39. On or about February 8, 2018, at 0925, Patient 2 was placed in physical restraints upon Respondent's order. But, at no point in the medical records does Respondent document the necessary elements involved in ordering physical restraints of a patient, including a timely assessment, medical justification, monitoring, reassessment, informed consent, and non-punitive use. On the date that physical restraints were ordered, ostensibly for placement of a nasogastric tube, Patient 2's vital signs showed a normal weight and did not indicate the necessity for the invasive tube placement. Moreover, there was no documentation that Patient 2 was a danger to herself or others requiring restraints. It appears from the records that Respondent ordered the restraints as a punitive measure because Patient 2 had removed the medically unnecessary nasogastric tube.

40. On or about February 7, 2018, Respondent ordered an involuntary injection of lorazepam without documenting any medical necessity for the involuntary administration of medication. Patient 2 refused the oral medication, and was injected against her will with the medication approximately 13 minutes later. Respondent failed to document that any less invasive measures were attempted, that Patient 2 was an imminent danger to herself or others, or any other reason to justify the involuntary medication administration. Moreover, the lorazepam was ordered in order to facilitate replacement of the medically unnecessary nasal gastric tube, further demonstrating that the involuntary administration of lorazepam was not medically necessary.

41. Patient 3

Patient 3, now a 19-year-old female, was admitted to the Alta Bates for psychiatric treatment for various conditions including, but not limited to, anorexia, depression/anxiety, and

self-harm behaviors. Patient 3's psychiatric admission at Alta Bates was from on or about February 5, 2021 through on or about March 1, 2021.

42. Respondent's documentation of treatment for Patient 3 was, similar to that of Patients 1 & 2 above: unintelligible, rambling, extremely repetitive, and very confusing. Respondent's documentation of psychiatric symptoms and history was inadequate and incomprehensible. The medical record is further disorganized, redundant, contradictory, and erroneous due to Respondent's repeated use of the copy and paste function to repeat information throughout each day's progress notes for Patient 3. It is unclear whether Respondent conducted good-faith psychiatric examinations of Patient 3, as the information documented in the progress notes between days was unchanged, and even included the same typos and spelling errors on each day the information was repeated in the medical record.

43. Respondent failed to perform good-faith, standard psychiatric evaluations of Patient 3 at any time during Patient 3's psychiatric treatment. A proper psychiatric exam would include, but not be limited to, (1) a description of the presenting problem; (2) psychiatric history recent and past including prior treating therapists, hospitalizations, medications, and interventions; (3) listing of past suicidal or violent acts; (4) history of substance abuse; (5) recording of medical treatments including past illnesses, hospitalizations, current conditions, medications, and treatments; (6) social history including family history, history of trauma; (7) education, military service, employment, economic status and spiritual involvement; (8) legal history; and (9) marriage, relationships, siblings, etc. As described above in paragraph 42, Respondent's progress notes are duplicative and vague, and do not include adequate information to show that good-faith psychiatric exams occurred on each, or any, day of Patient 3's psychiatric hospitalization.

44. Respondent failed to document the medical indication for the psychiatric treatment he prescribed, including multiple psychotropic medications and a nasogastric feeding tube. Respondent did not establish an evidentiary basis for his prescribing decisions, nor did Respondent keep adequate records of the evidence supporting the prescriptions or orders. Moreover, numerous medications, and the nasogastric feeding tube, were ordered without documenting the need for the medications and/or risks associated with prescribing multiple

medications, resulting in the prescription of medications without documented medical indication. Moreover, Respondent failed to document the medical necessity supporting Patient 3's inpatient psychiatric hospitalization, despite the risks of emotional trauma to Patient 3 from hospitalization, the most restrictive level of care in psychiatry.

45. Respondent did not maintain adequate records relating to Patient 3's voluntary inpatient psychiatric hospitalization. Patient 3 was 15-years-old at the time of hospitalization, and Respondent did not obtain Patient 3's written consent for her voluntary psychiatric hospitalization, and instead obtained written consent from Patient 3's parent. Despite Patient 3 meeting the age requirement for the LPS Act, Respondent did not include any documentation that Patient 3 consented to her inpatient hospitalization, in violation of Patient 3's rights. At numerous points in the medical records, Patient 3 makes clear she wants to leave the hospital. But, since Patient 3 was admitted on a voluntary status, she had the right to leave at any time. There is no documentation in the progress notes showing that the voluntary status of admission was ever provided to Patient 3.

46. Respondent likewise failed to obtain ongoing informed consent from Patient 3 for treatment. Informed consent is an ongoing process which requires documentation of disclosure of information important to the patient, to ensure the patient has the capacity to make treatment decisions without coercive influence. Typically, a psychiatrist would disclose an accurate description of the diagnosis, the proposed treatment, the risks and benefits associated with the proposed treatment, relevant alternatives (including no treatment at all), and the risks and benefits of each option. Informed discussion with the patient is a crucial component of the doctor/patient relationship, and of psychiatric treatment. There must be documentation of these discussions in the clinical record.

47. Patient 3 was prescribed multiple psychotropic medications, and there is no documentation that Respondent, or other staff, provided Patient 3 with any information regarding the psychotropic medications prescribed, including the indication, benefits and risks. There is likewise no documentation that any of this information was presented to Patient 3's parents. Respondent ordered a nasogastric tube for feeding Patient 3, a painful, dangerous, and invasive

intervention. There is no documentation that Respondent ever discussed the indications, risks, benefits, or side effects of this procedure with Patient 3 or her parents. Moreover, as noted above, there is insufficient documentation to even conclude that a nasogastric tube was medically necessary.

48. Respondent prescribed excessive, redundant, unnecessary, and dangerous polypharmacy to Patient 3. Respondent's prescriptions of multiple psychotropic medications were unsupported by clearly documented therapeutic purposes in the medical records. The multiple SSRI prescriptions, in combination with other serotonin activating medications (including the aripiprazole prescribed) increases a patient's potential for developing Serotonin Syndrome. This syndrome is a life-threatening condition with serious health outcomes. Respondent failed to consult an internist or cardiologist about the high risks associated with his prescriptions for potentially deadly cardiac conditions such as Torsades de Pointes. The combination of prescriptions given to Patient 3 risked this deadly cardiac condition, but nowhere does Respondent document that he consulted any other physicians about his decision to prescribe these medications, or to document that he informed Patient 3 of the risks of taking multiple medications.

49. Respondent failed to order and review necessary bloodwork and other diagnostic tests required to treat and monitor medical conditions and treatments. Laboratory testing is required when treating severe anorexia, for which Respondent treated Patient 3. Lab testing would be required to monitor for electrolyte imbalances, "refeeding" syndrome which can occur with severely malnourished patients like Patient 3, cardiovascular issues, vitamin and mineral deficiencies, liver and kidney function, anemia and blood cell abnormalities, endocrine abnormalities, bone health, blood glucose regulation, monitoring of medication side effects, and monitoring via x-ray the proper positioning of the nasogastric tube to ensure placement in the stomach. It does not appear that Respondent completed any of the required diagnostic tests for Patient 3's conditions, and failed to order and/or review the required blood work and diagnostic tests to monitor Patient 3's response to treatment.

50. Respondent failed to consult and collaborate with other physicians relating to Patient 3's care, despite the need to do so. Patient 3 suffered from severe anorexia and may have been suffering from a number of medical complications. There is no indication that Respondent ever consulted with a cardiologist, internist, or other physician to address Patient 3's complex medical condition.

51. Respondent failed to document whether he had a chaperone in the interview room, or whether he conducted the interviews with Patient 3 in full view of other staff. The presence of a chaperone reflects the standard of care to prioritize patient safety, enhance trust, provide dignity and comfort, and to maintain appropriate therapeutic boundaries. Here, Respondent failed to document whether he used a chaperone at any point during treatment of Patient 3.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence—Patient 1)

52. Respondent has subjected his license to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent was grossly negligent in his treatment and monitoring of Patient 1. The circumstances are as follows:

53. Complainant realleges paragraphs 12 through 26, and those paragraphs are incorporated by reference as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence—Patient 2)

54. Respondent has subjected his license to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent was grossly negligent in his treatment and monitoring of Patient 2. The circumstances are as follows:

55. Complainant realleges paragraphs 27 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence—Patient 3)

56. Respondent has subjected his license to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent was grossly negligent in his treatment and monitoring of Patient 3. The circumstances are as follows:

57. Complainant realleges paragraphs 41 through 51, and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing without Exam—Patient 1)

58. Respondent has subjected his license to disciplinary action under section 2242 of the Code, in that Respondent prescribed medication to Patient 1 without documenting an adequate examination of the patient. The circumstances are as follows:

59. Complainant realleges paragraphs 12 through 26, and those paragraphs are incorporated by reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing without Exam—Patient 2)

60. Respondent has subjected his license to disciplinary action under section 2242 of the Code, in that Respondent prescribed medication to Patient 2 without documenting an adequate examination of the patient. The circumstances are as follows:

61. Complainant realleges paragraphs 27 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing without Exam—Patient 3)

62. Respondent has subjected his license to disciplinary action under section 2242 of the Code, in that Respondent prescribed medication to Patient 3 without documenting an adequate examination of the patient. The circumstances are as follows:

63. Complainant realleges paragraphs 41 through 51, and those paragraphs are incorporated by reference as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts—Patient 1)

64. Respondent has subjected his license to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient 1.

65. Complainant realleges paragraphs 12 through 26, and those paragraphs are incorporated by reference as if fully set forth herein.

66. Respondent committed the following negligent acts during the care and treatment of Patient 1:

a) By failing to complete coherent, useful medical documentation regarding the patient's condition and/or treatment;

b) By failing to complete good-faith psychiatric exams of the patient;

c) By prescribing medications and a nasogastric feeding tube to the patient without documented medical indication;

d) By failing to support the patient's extensive inpatient psychiatric hospitalization with adequate documentation of medical necessity;

e) By failing to obtain written consent from the patient for his inpatient "voluntary" treatment, or to inform Patient 1 he was free to leave at any time;

f) By failing to document Patient 1's informed consent to psychiatric treatment and the use of experimental treatments, insertion of a nasogastric tube;

g) By prescribing a dangerous combination of medications to Patient 1;

h) By not ordering and/or reviewing the necessary bloodwork and other diagnostic tests indicated by Patient 1's medications, conditions, and treatments;

i) By failing to order, consult, and/or collaborate with the necessary medical professionals for Patient 1's medications, conditions, and treatments;

j) By repeatedly failing to utilize a chaperone during contacts and examinations with the patient; and

k) By using physical restraints on Patient 1 without adequate documentation of the medical justification.

EIGHTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts—Patient 2)

67. Respondent has subjected his license to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient 2.

68. Complainant realleges paragraphs 27 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

69. Respondent committed the following negligent acts during the care and treatment of Patient 2:

a) By failing to complete coherent, useful medical documentation regarding the patient's condition and/or treatment;

b) By failing to complete good-faith psychiatric exams of the patient;

c) By prescribing medications and a nasogastric feeding tube to the patient without documented medical indication;

d) By failing to support the patient's extensive inpatient psychiatric hospitalization with adequate documentation of medical necessity;

e) By failing to obtain written consent from the patient for her inpatient "voluntary" treatment, or to inform Patient 2 she was free to leave at any time;

f) By failing to document Patient 2's informed consent to psychiatric treatment and the use of experimental treatments, insertion of a nasogastric tube;

g) By prescribing a dangerous combination of medications to Patient 2;

h) By not ordering and/or reviewing the necessary bloodwork and other diagnostic tests indicated by Patient 2's medications, conditions, and treatments;

i) By failing to order, consult, and/or collaborate with the necessary medical professionals for Patient 2's medications, conditions, and treatments;

j) By repeatedly failing to utilize a chaperone during contacts and examinations with the patient;

k) By using physical restraints on Patient 2 without adequate documentation of the medical justification; and

l) By administering Patient 2 a sedative medication involuntarily without adequate medical necessity of documentation, as described above in paragraph 40 and incorporated herein by reference.

NINTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts—Patient 3)

70. Respondent has subjected his license to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient 3.

71. Complainant realleges paragraphs 41 through 51, and those paragraphs are incorporated by reference as if fully set forth herein.

72. Respondent committed the following negligent acts during the care and treatment of Patient 3:

a) By failing to complete coherent, useful medical documentation regarding the patient's condition and/or treatment;

b) By failing to complete good-faith psychiatric exams of the patient;

c) By prescribing medications and a nasogastric feeding tube to the patient without documented medical indication;

d) By failing to support the patient's extensive inpatient psychiatric hospitalization with adequate documentation of medical necessity;

e) By failing to obtain written consent from the patient for her inpatient "voluntary" treatment, or to inform Patient 3 she was free to leave at any time;

f) By failing to document Patient 3's informed consent to psychiatric treatment and the use of experimental treatments, insertion of a nasogastric tube;

g) By prescribing a dangerous combination of medications to Patient 3;

h) By not ordering and/or reviewing the necessary bloodwork and other diagnostic tests indicated by Patient 3's medications, conditions, and treatments;

i) By failing to order, consult, and/or collaborate with the necessary medical professionals for Patient 3's medications, conditions, and treatments; and

j) By repeatedly failing to utilize a chaperone during contacts and examinations with the patient.

TENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records—Patient 1)

73. Respondent has subjected his license to disciplinary action under section 2266 of the Code, for failure to maintain adequate and accurate medical records regarding his care and treatment of Patient 1. The circumstances are as follows:

74. Complainant realleges paragraphs 12 through 26, and those paragraphs are incorporated by reference as if fully set forth herein.

ELEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records—Patient 2)

75. Respondent has subjected his license to disciplinary action under section 2266 of the Code, for failure to maintain adequate and accurate medical records regarding his care and treatment of Patient 2. The circumstances are as follows:

76. Complainant realleges paragraphs 27 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records—Patient 3)

77. Respondent has subjected his license to disciplinary action under section 2266 of the Code, for failure to maintain adequate and accurate medical records regarding his care and treatment of Patient 3. The circumstances are as follows:

78. Complainant realleges paragraphs 41 through 51, and those paragraphs are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 50347, issued to Respondent Neal Anzai, M.D.;

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

3. Ordering Respondent Neal Anzai, 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: MAR 25 2025

for

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

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