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

In the Matter of the Second Amended Accusation Against: **Tara Alaina Zandvliet, M.D.** **Physician's and Surgeon's Certificate No. A 71646** **Respondent.**	**Case No.: 800-2017-035630**

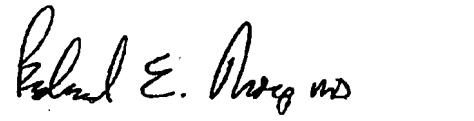
DECISION

The attached Stipulated Settlement 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 January 21, 2022.

IT IS SO ORDERED: December 23, 2021.

MEDICAL BOARD OF CALIFORNIA



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

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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 Second Amended Accusation Against: **TARA ALAINA ZANDVLIET, M.D.** **2991 Kalmia St.** **San Diego, CA 92104** **Physician's and Surgeon's Certificate No. A 71646** Respondent.	Case No. 800-2017-00305630 OAH No. 2020120905 **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. William Prasifka (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 Tessa L. Heunis, Deputy Attorney General.

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2. Respondent Tara Alaina Zandvliet, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about May 11, 2000, the Board issued Physician's and Surgeon's Certificate No. A 71646 to Tara Alaina Zandvliet, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 800-2017-00305630, and will expire on July 31, 2023, unless renewed.

JURISDICTION

4. On August 13, 2020, Accusation No. 800-2017-00305630 was filed before the Board. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent, and Respondent timely filed her Notice of Defense contesting the Accusation. Subsequently, on November 30, 2020, First Amended Accusation 800-2017-00305630 was filed before the Board, and on September 9, 2021, Second Amended Accusation No. 800-2017-00305630 was filed before the Board and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent and all allegations therein were deemed controverted. A true and correct copy of Second Amended Accusation No. 800-2017-00305630 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Second Amended Accusation No. 800-2017-00305630. Respondent has also carefully read, fully discussed with her counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Second 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.

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Second Amended Accusation No. 800-2017-00305630.

9. Respondent agrees that her Physician's and Surgeon's Certificate No. A 71646 is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

10. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that she may not withdraw her agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

11. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value

whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

12. 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.

13. 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 agreements of the parties in the above-entitled matter.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 71646 issued to Respondent Tara Alaina Zandvliet, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Decision on the terms and conditions set out below. This Order supersedes the probationary order in Case No. 800-2017-032412.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules III, IV and V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If

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

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

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

address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

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

3. 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.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine

safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

6. PROHIBITED PRACTICE. During probation, Respondent is prohibited from making or issuing any written exemption from immunization, or any other written statements providing that any child is exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 of the Health and Safety Code. After the effective date of this Decision, all patients being treated by Respondent shall be notified of this prohibition. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for

immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

As used in this section, "patient(s)" refers to minor patients and their parents, custodians and other legal guardians.

7. 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.

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

9. 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.

10. 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.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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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.

12. 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.

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

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

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

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

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

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

14. 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. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. 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.

16. 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 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.

17. 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.

18. 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 Second Amended Accusation No. 800-2017-00305630 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and

the effect it will have on my Physician's and Surgeon's Certificate No. A 71646. 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: 9/17/21

TARA ALAINA ZANDVLIET, M.D.
Respondent

I have read and fully discussed with Respondent Tara Alaina Zandvliet, 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: September 17, 2021

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: September 20, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

TESSA L. HEUNIS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Second Amended Accusation No. 800-2017-00305630

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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 Second Amended Accusation Against: **TARA ALAINA ZANDVLIET, M.D.,** **2991 Kalmia St.** **San Diego, CA 92104** **Physician's and Surgeon's Certificate No. A 71646,** Respondent.	Case No. 800-2017-035630 **SECOND AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Second 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 11, 2000, the Board issued Physician's and Surgeon's Certificate No. A 71646 to Tara Alaina Zandvliet, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2023, unless renewed.

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JURISDICTION

3. This Second Amended Accusation, which supersedes the First Accusation filed on November 30, 2020, in the above-entitled matter, is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

...

6. Section 2266 of the Code states:

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

7. 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 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

...

(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.

...

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8. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

9. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

...

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Unprofessional conduct under Business and Professions Code section 2234 is conduct that breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

OTHER RELEVANT STATUTORY PROVISIONS

11. Section 120335 of the Health and Safety Code states:

(a) As used in this chapter, 'governing authority' means the governing board of each school district or the authority of each other private or public institution responsible for the operation and control of the institution or the principal or administrator of each school or institution.

(b) The governing authority shall not unconditionally admit any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless, prior to his or her first admission to that institution, he or she has been fully immunized. The following are the diseases for which immunizations shall be documented:

(1) Diphtheria.
(2) Haemophilus influenzae type b.
(3) Measles.
(4) Mumps.
(5) Pertussis (whooping cough).
(6) Poliomyelitis.
(7) Rubella.
(8) Tetanus.
(9) Hepatitis B.
(10) Varicella (chickenpox).

[1] *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(c) Notwithstanding subdivision (b), full immunization against hepatitis B shall not be a condition by which the governing authority shall admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school.

(d) The governing authority shall not unconditionally admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school unless the pupil has been fully immunized against pertussis, including all pertussis boosters appropriate for the pupil's age.

(e) The department may specify the immunizing agents that may be utilized and the manner in which immunizations are administered.

...

(g)(1) A pupil who, prior to January 1, 2016, submitted a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization shall be allowed enrollment to any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span.

(2) For purposes of this subdivision, 'grade span' means each of the following:

(A) Birth to preschool.

(B) Kindergarten and grades 1 to 6, inclusive, including transitional kindergarten.

(C) Grades 7 to 12, inclusive.

(3) Except as provided in this subdivision, on and after July 1, 2016, the governing authority shall not unconditionally admit to any of those institutions specified in this subdivision for the first time, or admit or advance any pupil to 7th grade level, unless the pupil has been immunized for his or her age as required by this section.

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12. Section 120370 of the Health and Safety Code states:[2]

(a) (1) Prior to January 1, 2021, if the parent or guardian files with the governing authority a written statement by a licensed physician and surgeon to the effect that the physical condition of the child is such, or medical circumstances

[2] Effective January 1, 2016, through December 31, 2019, Health and Safety Code section 120370, subdivision (a), stated: "If the parent or guardian files with the governing authority a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician does not recommend immunization, that child shall be exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician's statement."

relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician and surgeon does not recommend immunization, that child shall be exempt from the requirements of this chapter, except for Section 120380, and exempt from Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician and surgeon's statement.

(2) Commencing January 1, 2020, a child who has a medical exemption issued before January 1, 2020, shall be allowed continued enrollment to any public or private elementary or secondary school, child care center, day nursery, nursery school, family day care home, or developmental center within the state until the child enrolls in the next grade span.

For purposes of this subdivision, "grade span" means each of the following:

(A) Birth to preschool, inclusive.

(B) Kindergarten and grades 1 to 6, inclusive, including transitional kindergarten.

(C) Grades 7 to 12, inclusive.

...

DEFINITIONS

13. Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California. It is compiled by the California Department of Justice, Bureau of Criminal Identification and Investigative Services as part of its Prescription Drug Monitoring Program.

14. Oxycontin is the brand name of a time-release formula of oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Oxymorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Dilaudid is a brand name for hydromorphone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

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18. Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salt used for attention-deficit hyperactivity disorder and narcolepsy.

19. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Hydrocodone Bitartrate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Xanax is a brand name for alprazolam (a benzodiazepine), a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Tramadol, an opioid analgesic, is a Schedule IV drug under the Uniform Controlled Substances Act and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Soma, a muscle relaxant, is a brand name for carisoprodol, a Schedule IV drug under the Uniform Controlled Substances Act.

24. Narcan is a brand name for naloxone, a medication used to block the effects of opioids. It is commonly used to counter decreased breathing in opioid overdose, and is a dangerous drug pursuant to Business and Professions Code section 4022.

25. Suboxone contains buprenorphine and naloxone. It is a Schedule V controlled substance under Health & Safety Code Section 11058(d), and a dangerous drug pursuant to Business and Professions Code section 4022. Suboxone is FDA-approved for treatment of opioid addiction.

26. Gabapentin is most commonly prescribed to relieve nerve pain, and is a dangerous drug pursuant to Business and Professions Code section 4022.

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27. Selective serotonin re-uptake inhibitors or serotonin-specific reuptake inhibitors (SSRIs) are a class of compounds typically used as antidepressants in the treatment of depression anxiety disorders, and some personality disorders.

28. Lexapro is a brand name for escitalopram, an SSRI antidepressant. Lexapro is used to treat depression and anxiety in adults, and is a dangerous drug pursuant to Business and Professions Code section 4022.

29. Cyclic antidepressants are designated as tricyclic or tetracyclic, depending on the number of rings in their chemical structure — three (tri) or four (tetra). Tricyclic antidepressants are older drugs than SSRIs, work differently, and have different side-effects.

30. Cyclobenzaprine is a muscle relaxant that is closely related (has a similar chemical structure) to the tricyclic antidepressants (eg, amitriptyline, imipramine). Flexeril is a brand name for cyclobenzaprine that has been discontinued in the U.S., but cyclobenzaprine remains available in other brand names. It is a dangerous drug pursuant to Business and Professions Code section 4022.

31. Nonsteroidal anti-inflammatory drugs (NSAIDs) are drugs used to treat inflammation, mild to moderate pain, and fever. They include aspirin and ibuprofen.

32. The "five A's" of chronic pain management are: analgesia, adverse side effects, functional activities, aberrancy, and patient affect.

33. Morphine Equivalent Dosage (MED) is a value assigned to opioids to represent their relative potencies. MED is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the ordered opioid. Daily MED (or MEDD) is the sum of the MED of all drugs in the opioid class a patient is likely to take over 24 hours, and that total is used to determine if the patient is nearing a potentially dangerous threshold. The primary side effect of opioid overdose is respiratory depression, which frequently leads to serious complications or death. Ideally, the MED of a patient's daily opiate therapy should not exceed 80-90 mg per day. Risks of adverse effects, including drug overdose and death, increase significantly beyond this dosage.

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34. The DTaP vaccine protects against diphtheria, tetanus, and pertussis (whooping cough). Diphtheria is a serious infection of the throat that can block the airway and cause severe breathing problems. Pertussis is a respiratory illness with cold-like symptoms that lead to severe coughing (the "whooping" sound happens when a child breathes in deeply after a severe coughing fit). Serious complications can affect children under 1 year old, and those younger than 6 months old are especially at risk. Teens and adults with a lasting cough might have pertussis and not realize it, and could pass it to vulnerable infants.

35. The Tdap vaccine is a booster immunization given at age 11 that offers continued protection from diphtheria, tetanus, and pertussis for adolescents and adults.

36. Polio, or poliomyelitis, is a disabling and life-threatening disease caused by the poliovirus. The virus spreads from person to person and can infect a person's spinal cord, causing paralysis. Paralysis, in turn, can lead to permanent disability and death.

37. Varicella, also known as chickenpox, is a very contagious disease caused by the varicella-zoster virus (VZV). It causes a blister-like rash, itching, tiredness, and fever. Chickenpox used to be very common in the United States. Serious complications of chickenpox can lead to hospitalization and death.

38. The MMR vaccine protects against measles, mumps and rubella. Measles is highly contagious and especially dangerous for babies and young children. It can lead to pneumonia, lifelong brain damage, deafness and death.

39. Hepatitis A is a serious liver disease. In rare cases, hepatitis A can cause liver failure and death. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

40. The Hib vaccine protects against *haemophilus influenzae* type b, a disease that can cause serious illness and death in babies and children younger than 5 years old. Hib can cause severe infections of both the lining of the brain and spinal cord (meningitis) and the bloodstream.

41. Influenza (flu) is a contagious respiratory illness caused by influenza viruses that can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death, particularly in older people, young children, and people with certain health conditions.

42. Meningitis is an inflammation (swelling) of the protective membranes covering the brain and spinal cord. Bacterial meningitis can be deadly and requires immediate medical attention.

43. The HPV vaccine protects against the human papillomavirus, a very common virus that can lead to cancer.

FACTUAL ALLEGATIONS

44. At all relevant times, Respondent practiced internal medicine and pediatrics at her solo practice, South Park Doctors.

Patient A:

45. Patient A[3] is a male minor child, born in March 2015.

46. At all times relevant to the allegations herein, Patient A received care from providers within the Kaiser Permanente healthcare system ("Kaiser").

47. Respondent saw Patient A on one occasion only, on or about March 24, 2017. On this occasion, Patient A was brought to Respondent by his parents "for consultation about vaccines and possible medical exemption" from vaccines. At the time of the visit, Patient A had received no vaccinations.

48. Patient A's family history was recorded in his chart by Respondent as follows:

a. Second cousin – "bee sting allergy epi pen"

b. Cousin #1 – penicillin allergy

c. Cousin #2 – Hashimotos

d. Great aunt – "food allergies"

e. Great grandmother – "food allergies"

f. Great grandfather – polyarteritis Nodosa

g. Maternal grandmother – "RA, lupus"

h. Mother – "[consistent with] Hashimotos, no confirmation yet"

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[3] For the sake of patient privacy, all patients involved in this Second Amended Accusation are designated only as "Patient A," "Patient B," etc. Their identities are known to all parties.

Patient A's chart contains what Respondent regards as documentation that supports the family history for the first six persons listed above (13a through 13f).

49. Patient A's past medical history, as recorded by Respondent in Patient A's chart, reflects "asthma, allergies – possibly food, definitely environmental."

50. Patient A's medical records at Kaiser reflect no known allergies. He received treatment (Zyrtec and Flovent) for environmental allergies, but testing for environmental allergies at age 2 years identified only animal (dog and cat) dander as allergy triggers. He was also hospitalized at age 2 for asthma exacerbation and discharged after one day. He visited the emergency room for diarrhea at 9 months of age.

51. Patient A was diagnosed with hand foot mouth disease at 12 months, and had pertussis when he was 2 ½ years old (January 4, 2018), for which both he and his entire family required antibiotic treatment. Pertussis is a vaccine preventable disease.

52. Respondent failed at any stage to consult Patient A's providers at Kaiser or review his Kaiser medical records.

53. In considering the request for a vaccine exemption, Respondent looked for "evidence that the family was of an allergic or atopic autoimmune type." Since Respondent found that Patient A has asthma and allergies, she considered him more likely to have anaphylaxis to many different things, including vaccines.

54. Based on "a family history of hyperimmunity and autoimmunity," Respondent's opinion was "to vaccinate slowly, [but to have] an exemption for school attendance. Choice to vaccine is up to parents." Respondent "encouraged a slow schedule."

55. On or about March 24, 2017, Respondent prepared the following document, providing Patient A with a permanent medical exemption from all vaccines on the Center for Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines:

> [Patient A] DOB 3/[xx]/15 has a strong family history of Autoimmune diseases like polyarteritis Nodosa and hyperimmune conditions like anaphylaxis. Given the level of immune dysfunction in him and the family, I feel he is at a high risk of adverse reaction to vaccines. If there is an imminent medical threat in the community we can consider a single vaccine in a controlled medical environment, however, the benefits to him and the community must greatly outweigh his very real personal risk. This medical exemption for vaccines is permanent. It includes, but is not limited to,

DtaP [*sic*], TdaP, Polio, Varicella, MMR, Hep B and A, HiB, HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC recommended vaccine list and any future vaccines placed on the list.

56. At an interview conducted on behalf of the Board on August 3, 2020 ("the first subject interview"), Respondent explained that she made the exemption permanent because family history "does not change for the better, it just gets worse as we diagnose more things ...; the diagnoses won't disappear." Also, the reason she made the exemption for all vaccines, both the (known) current ones and any unknown future vaccines, is because "the schools and the law require they all be listed" and the schools "wanted broad letters." In addition, since the immune system of Patient A, "based on personal history and family history is more of an atopic nature, [he] would be at a higher risk of anaphylaxis and allergic reaction to any vaccine because of the immune process; it's not vaccine specific."

57. Respondent's explanation and/or rationale for providing Patient A with an exemption from all vaccinations, current and future, was not consistent with, and was in direct opposition to, the recommendations of the CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies. In fact, patients with allergies (for instance, asthma or eczema) are at greater risk from the vaccine preventable diseases (for instance, influenza in the case of patients with asthma, and varicella in the case of patients with eczema), so that vaccine is highly recommended in these patients, not contraindicated or cautioned against.

58. Respondent has estimated that, between the passing of California Senate Bill 277[4] and June 2019, she provided roughly 1,000 medical exemptions. At the first subject interview, she was unable to provide any approximation of the breakdown between permanent and temporary exemptions.

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[4] California Senate Bill 277 was a California bill that removed personal belief exemptions to vaccination requirements for entry to private or public elementary or secondary schools in California, as well as day care centers. It was passed in the California State Senate in June 2015 and signed into law by Governor Jerry Brown on June 30, 2015.

Patient B:[5]

59. Patient B is an adult female born in 1988, who suffered from loin pain hematuria syndrome due to IgA nephropathy.[6]

60. Patient B started filling opiate prescriptions from Respondent in the second half of 2014, and had received opiates from other providers for roughly the first half of 2014:

Time Frame	**Jan. 1- Jun. 23, 2014 (other providers)**	**Jun. 24 – Dec. 31, 2014 (Respondent)**
Oxycodone	42,700 mg	90,360 mg
Hydromorphone	2,040 mg	2,880 mg
Oxycontin	2,640 mg	31,200 mg
Morphine sulfate	900 mg	
Oxymorphone		1,800 mg
Fentanyl transdermal	12 mcg/1 hr x 10	
Hydrocodone	1,220 mg	

61. At the time that Respondent assumed the sole prescribing responsibility of narcotics for Patient B (in June 2014), she had been receiving approximately 424 mg MEDD from her prior providers. Respondent escalated Patient B's narcotic prescriptions over the next 18 months so that, by December 2015, Patient B was receiving approximately 1227 mg MEDD.

62. In January 2016, Respondent was prescribing oxycodone IR, Dilaudid, and Oxycontin SR, such that Patient B's MED was approximately 1360 mg per day.

63. During the approximately three and a half year period of records reviewed, Respondent made attempts to taper down Patient B's narcotic requirements. By the end of June 2016, Patient B was down to approximately 970 mg MEDD, and by December 2016 she was down to approximately 938 mg MEDD. (For the entire 2016 year, Patient B received an MEDD in excess of 900 mg.) The lowest MEDD reached during the period reviewed for Patient B, was approximately 795 mg in December 2017.

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[5] Records reviewed for Patient B cover the period January 4, 2016 through June 10, 2019.

[6] IgA nephropathy is a chronic kidney disease. It progresses over 10 to 20 years, and it can lead to end-stage renal disease.

64. Respondent's attempts to wean Patient B from her high doses of narcotics were often interrupted by Patient B's self-reported flares of her back and loin pains. However, her chart contains no documentation of objective evidence of the flare-ups of her kidney condition, such as hematuria,[7] fevers, imaging, or laboratory assessment. Respondent's clinical documentation also does not reflect any objective findings of the flare-ups and contains minimal functional and pain intensity assessments.

65. Respondent's chart for Patient B, generally, contains no detailed review of symptoms and no thorough physical examination findings. The progress notes make no reference to the "five A's" of chronic pain management.

66. In March 2018, Patient B was involved in a motor vehicle accident. By June 2018, Patient B was again receiving approximately 1017 mg MEDD, which was again weaned down to roughly 930 MEDD by the end of June 2019. This MEDD has remained at approximately the same level consistently, through at least July 1, 2020.

67. Patient B's chart does not show that any non-opiate drug therapies were tried (concurrently with long term opiates), such as tricyclic antidepressants, serotoninergic medications, muscle relaxants, anti-seizure medications, and/or topical therapies. Cognitive behavioral therapies with mental health experts were not part of a multi-disciplinary approach by Respondent to managing Patient B's condition.

68. Respondent's chart for Patient B shows a rheumatology referral in March 2016 for possible rheumatoid arthritis suspected due to swollen hands, and documents that Patient B would be undergoing a nerve block procedure "on May 19." A progress note dated September 14, 2016, documents that Patient B would be having denervation and ablation surgery of the kidney for pain management, "far in the future." The chart does not document any follow-up to these anticipated consultations and/or pain management procedures.

69. In the progress note dated January 3, 2017, Respondent noted that Patient B was "narcotic dependent" with a high opiate tolerance. January 3, 2017, also marks the first date on which there is a documented reference to the CURES database in Patient B's chart (for the period

[7] The presence of blood in the urine.

reviewed). During Patient B's continued fortnightly visits to Respondent for the ensuing thirty (30) month period (between January 2017 and June 10, 2019), Respondent documented checking Patient B's CURES a further eleven (11) times.

70. Patient B's chart for the three and a half year period reviewed includes five (5) documented drug toxicology tests, with the first such test being in April 2017, followed by October 2017, February 2018, June 2018, and February 2019.

71. The first reference to pain management in Patient B's chart is in a progress note dated February 2, 2018, and states, "consider pain management." Pain management is again mentioned in a progress note dated January 2, 2019, and again on or about April 4, 2019. Respondent remained the sole prescriber of Patient B's opiate medications.

72. A progress note in Patient B's chart dated May 14, 2018, references a diagnosis of "sleep apnea – mild." Pain medications often worsen apneic episodes during sleep and would have magnified Patient B's respiratory risks. The diagnosis of sleep apnea did not lead to any marked tapering by Respondent of Patient B's opiate medications.

73. Patient B's chart does not reflect that Respondent attempted to taper her opiates by rotation to different opiates.

74. The only prescription for Naloxone found in Patient B's chart is dated January 15, 2018, for one nasal spray 4 mg with two (2) refills.

75. There are no vital signs recorded in Patient B's chart throughout the period reviewed.

76. A progress note in Patient B's chart dated January 3, 2017, documents the reason for the visit as "here for follow up of the swollen lymph nodes." The note does not indicate which lymph nodes were swollen and contains no details of a physical examination.

Patient C:[8]

77. Patient C is an adult male born in 1985. He received care and treatment from Respondent for shoulder pain due to rotator cuff injury, chronic low back pain (that "came and went") due to degenerative disc disease, and management of diabetes.

[8] Records reviewed for Patient C cover the period November 20, 2015, through June 1, 2019 ("the Patient C period reviewed").

78. A CURES report for Patient C shows that, prior to becoming Respondent's patient, he filled prescriptions issued by a different provider for oxycodone (10 mg per day), on or about July 15, 2014, August 5, 2014, and September 2, 2014. When Respondent assumed the care of Patient C, she escalated Patient C's opiate dosage: on or about October 28, 2014, Respondent issued Patient C a prescription for oxycodone 10 mg x 60, and seven days later, on or about November 5, 2014, another prescription for oxycodone 10 mg x 180.

79. Between October 28, 2014, and January 25, 2015 (90 days), Patient C filled prescriptions issued by Respondent for oxycodone 10 mg x 600 tablets[9] and carisoprodol 350 mg x 180 tablets.

80. On or about January 26, 2015, Patient C filled prescriptions from Respondent for oxycodone 10 mg x 180, and nine (9) days later, on or about February 4, 2015, a prescription from Respondent for oxycodone 15 mg x 180. Between February 4, 2015, and June 16, 2015 (133 days), Patient C filled prescriptions from Respondent for oxycodone 15 mg x 1,040.[10]

81. From on or about June 17, 2015, Patient C started filling monthly prescriptions from Respondent for an increased dose of oxycodone (30 mg x 120 tablets), and also started filling monthly prescriptions for morphine sulfate 30 mg x 90 tablets. This represented a consistent MEDD of 270 mg.

82. On or about April 11, 2016, Respondent increased the morphine sulfate to 60 mg x 90 tablets per month, raising the MEDD from 270 mg to a consistent 360 mg for at least the ensuing 3.5 years.

83. For the five year period from June 17, 2015, through at least July 1, 2020,[11] Respondent prescribed Patient C a combination of oxycodone 30 mg x 120 per month, and MS Contin 30 mg or 60 mg (as indicated above) x 90 per month.

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[9] An average of 6.67 x oxycodone 10 mg tablets per day.
[10] An average of 7.8 x oxycodone 15 mg tablets per day.
[11] A CURES report was obtained for Patient C, ending July 1, 2020.

84. From November 21, 2014, through at least July 1, 2020, Respondent also prescribed carisoprodol 350 mg x 90 per month as a muscle relaxant for Patient C's low back pain, to be taken concurrently with the oxycodone and morphine sulfate as indicated above.[12]

85. Patient C's chart contains no imaging results or surgical consultations for confirmation of either Patient C's rotator cuff complaint or of his degenerative spine, or the severity of either complaint.

86. The first documentation of the pain intensity scale in the Patient C period reviewed is found in the progress note dated November 17, 2016, with the comment, "Meds work well, get pain down to about a 4/10." The pain medications were not decreased.

87. The first documentation of any toxicology testing of Patient C is found in the progress note dated January 9, 2017. Patient C's chart for the entire period reviewed shows four (4) drug toxicology tests.[13]

88. No CURES queries are documented in Patient C's chart.[14] A CURES report for Patient C reveals that he was prescribed Suboxone 8 mg-2 mg x 60 tablets on April 12, 2018, and again on April 17, 2018, by a provider other than Respondent. Respondent was unaware of these prescriptions and failed to recognize possible opiate addiction in Patient C.

89. On or about September 7, 2018, Respondent "offered" Narcan to Patient C for prevention of opiate toxicity or potential drug overdoses; however, no prescriptions for Narcan can be found in Patient C's chart for the period reviewed.

90. On or about April 11, 2016, Respondent noted in Patient C's chart that his primary care physician should refer him to pain management and orthopedics. Respondent did not initiate the consultations and Patient C's chart makes no reference to whether these referrals were ever given or acted upon.[15]

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[12] The first morphine sulfate prescription was filled on or about June 17, 2015.

[13] On or about January 9, 2017, March 9, 2018, December 14, 2018, and May 17, 2019.

[14] At an interview with Respondent on or about August 18, 2020 ("the second subject interview"), Respondent stated she "was accustomed to checking CURES and ... doing drug tests and often did not write it down..."

[15] At the second subject interview, Respondent stated Patient C did not receive these referrals since he did not have insurance.

91. On or about May 30, 2016, Respondent referred Patient C to home physical therapy exercises and considered the possibility of acupuncture therapy, while continuing Patient C on the same dosage of narcotics. Respondent did not initiate any acupuncture referral or follow through with a trial of acupuncture therapy.

92. On or about August 2, 2016, Respondent referred Patient C to UCSD mental health clinic for management of his anxiety[16]. A prescription for alprazolam 0.5 mg was added in February 2019, but Patient C's chart does not reflect that he received any psychiatric help from August 2016 through the remainder of the Patient C period reviewed.

93. On or about June 12, 2017, Respondent referred Patient C to an otolaryngologist (ear, nose and throat physician) and for a polysomnogram for evaluation of obstructive sleep apnea. Patient C's chart contains no consultation notes or sleep study results and it is not clear if he was fully evaluated for this condition.

94. Respondent did not taper Patient C's opiate usage in light of the clinical concern for obstructive sleep apnea, and continued prescribing him three controlled substances that suppress respiration (namely, oxycodone, morphine sulfate, and carisoprodol).

95. On or about February 15, 2019, Respondent noted in Patient C's chart that she was discontinuing carisoprodol and starting alprazolam 0.5 mg for anxiety. Two prescriptions of 20 x 0.5 mg tablets were written by Respondent on or about February 15, 2019, and filled by Patient C in May 2019.

96. Carisoprodol prescriptions were filled in March 2019 and again on a monthly basis from May 2019 onwards. Patient C's chart does not reflect the effect of the alprazolam tablets on Patient C's anxiety, or why they were apparently stopped and the carisoprodol resumed.

97. There are no vital signs (and weight) recorded in Patient C's chart for the entire period reviewed. At the second subject interview, Respondent stated that she "was not accustomed to taking vital signs unless it was necessary for what [she] was doing.... [She] occasionally... would do the blood pressure, checking that it wasn't too low."

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[16] Worsening anxiety and panic attacks experienced by opiate dependent patients are often warning signs of opiate withdrawal and physical dependency.

98. During the Patient C period reviewed, Respondent did not try non-opiate medications such as tricyclic antidepressants or anti-seizure medications, or the use of safer muscle relaxants and topical analgesic creams concurrently with the opiate therapy.

99. Patient C's chart does not show an adequate risk assessment of Patient C nor a recognition by Respondent that Patient C had elevated addiction risks due to his anxiety disorder, young age, and male sex.

100. Respondent's care and treatment of Patient C shows no recognition of Patient C's development of opiate tolerance (based on the high opiate dosage he required daily), and she did not taper down his narcotics or rotate to different opiate medications.

101. Many progress notes in Patient C's chart had no physical examination findings or functional assessments to justify Patient C's high opiate dosage. The records also do not include the components of an adequate diabetic management, including annual eye examinations and feet examinations, and regular blood monitoring.

102. A prescription for Lexapro (with five (5) refills) dated May 17, 2019, is contained in Patient C's chart. Respondent's progress notes for Patient C make no mention of this medication.

103. Respondent issued prescriptions for Patient C for ibuprofen 800 mg x 90 tablets in November 2015, January 2016, January 2018, and February 2019.

Patient D:

104. Patient D is a female adult born in 1986, who suffered from multiple medical illnesses, including chronic granulomatous disease ("CGD"),[17] depression and anxiety, attention deficit disorder ("ADD"), cirrhosis, and chronic low back pains of unknown etiology.[18]

105. For at least the three and a half year period between December 30, 2015, and June 1, 2019 ("the Patient D period reviewed")[19] and continuing until at least July 1, 2020,[20] Respondent

[17] Chronic granulomatous disease ("CGD") is a genetic disorder that causes the immune system to malfunction, resulting in a form of immunodeficiency and leading to recurrent infections and inflammations of the body. Chronic pain syndrome is a potential complication of this disease.

[18] Due to Patient D's high risk of recurrent infections, spinal inflammation was a potential source of her back pains.

[19] Respondent started treating Patient D before 2015, possibly as early as 2012.

[20] A CURES report was obtained for Patient D, ending July 1, 2020.

consistently prescribed to Patient D a combination of Morphine SR 180 mg and oxycodone 330 or 360 mg daily, amounting to an MEDD of approximately 720 mg.[21] During the same period, Patient D also consistently received from Respondent alprazolam 6 mg daily (for her long-term anxiety disorder) and Adderall 60 mg daily (for ADD).

106. Patient D saw Respondent on two occasions during the calendar year 2016 (August and December), and four times in 2017 and 2018, respectively.

107. Respondent listed chronic granulomatous disease as the main indication for long-term pain management of Patient D, but her chart is frequently silent on the specific source(s) of the pain and their association with CGD. In February 2019, there are references in Patient D's chart to pancreatitis, pyelonephritis and kidney stones. These painful conditions were likely evaluated during Patient D's hospital stays for recurrent infections, but the hospital records were not contained in Patient D's chart.

108. An MRI of Patient D's back was ordered in July 2017, but no report is found in Patient D's chart and no results are documented in the notes.

109. During the Patient D period reviewed, Respondent made (unsuccessful) documented attempts to taper down Patient D's narcotic dosage. No attempt was made to manage Patient D's chronic pain syndrome through an outpatient multi-disciplinary approach, including surgical consultations with orthopedics for back pains, urology for kidney stones, medical consultations with gastroenterology for pancreatitis, anesthesiology for nerve blocks and ablation, pain management consultations, and primary care coordination of ancillary treatments like weight loss, acupuncture, and chiropractic adjustments.

110. Patient D's chart shows no trials of tricyclic medications, anti-seizure medications, muscle relaxants, and/or topical therapies, to try to reduce Patient D's dependency on high dose narcotics.

111. Respondent recommended and referred Patient D to mental health providers in November 2018 to better manage her depression and anxiety. It is unknown whether Patient D

[21] A prescriber CURES report for Respondent, starting in August 2015, shows that Patient D was filling similar prescriptions issued by Respondent as early as August 2015.

complied with the recommendation, as the chart contains no consultation reports or documentation of any conversations with any mental health providers.

112. Patient D's chart shows only two documented drug toxicology tests for the entire period reviewed. The chart contains one CURES report dated December 30, 2015 (covering the calendar year 2015), and one dated May 11, 2016 (covering the prior six month period, starting November 11, 2015).

113. Patient D's chart shows no risk assessment of Patient D (including documentation of her social history and issues such as smoking and/or alcoholism, which increase addiction risks), or an appreciation by Respondent that Patient D had elevated addiction risks due to her youth and psychiatric conditions.

114. Patient D's chart shows no appreciation or recognition by Respondent of Patient D's opiate tolerance and the inherent risks from a narcotic dosage of 720 mg MEDD. Respondent did not taper down Patient D's narcotic prescriptions or rotate to different opiate medications if needed.

115. Respondent also provided stimulant Adderall therapy of 60 mg daily to Patient D during the entire period reviewed, for treatment of her ADHD.[22] Patient D's chart for the period reviewed contains no documentation to confirm the diagnosis, or evidence of a clinical assessment or attempt to reduce Patient D's Adderall dosage.[23]

116. Respondent's progress notes for Patient D are sparsely notated. No vital signs (including blood pressure and weight) were recorded in Patient D's chart throughout the period reviewed, and there is no (or insufficient) documentation of the "five A's" of chronic pain management, or of thorough physical examinations and functional assessments. No consultation reports are contained in Patient D's chart for the period reviewed.

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[22] A CURES report found in Patient D's chart for the calendar year 2015 shows that Patient D was receiving this dose of Adderall as early as January 2015.

[23] Adderall's side effects include worsening of anxiety, elevations in blood pressure and heart rate, and arrhythmias.

Patient E:

117. Patient E is an adult male born in 1985, whose primary complaint was knee pain. He received care and treatment from Respondent from 2014 through 2018.

118. From July 2015 through January 2018 ("the Patient E period reviewed"),[24] Respondent prescribed a combination of hydrocodone 325/10 mg and oxycodone 325/10 mg concurrently, with intermittent tramadol 50mg,[25] for Patient E's knee pain. Respondent also prescribed morphine sulphate 30 mg, and morphine sulphate 60 mg, for Patient E on one occasion.

119. For the entire 2016, Patient E averaged approximately 120 mg MEDD with intermittent Tramadol tablets.

120. For the entire 2017, Patient E averaged approximately 73 mg MEDD.

121. During the entire Patient E period reviewed, Respondent obtained no imaging or surgical evaluation of Patient E's chronic knee pains.

122. Respondent conducted minimal physical examination of Patient E's knee(s). The following are the entirety of the documented knee examinations in Patient E's chart during the period reviewed:

August 13, 2015: "PE – Left knee with tenderness, crepitus; No instability"

September 28, 2015: "PE Knewws [sic] with crepitus"

October 12, 2015: "PE – knee with crepitus, decreased range of motion"

July 6, 2016: "PE – … Neg straight leg raise"

July 11, 2016: "PE – left knee with crepitus; Decreased flexion

September 6, 2016: "PE – left knee with crepitus"

October 12, 2016 "PE – left knee effusion; Tenderness at patella; Decreased flexion; limping"

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[24] Records reviewed for Patient E cover the period July 1, 2015, through January 2018.
[25] The most recent fill date for tramadol appears to have been September 23, 2016.

February 20, 2017: "PE – left knee with crepitus; No instability, neg ant drawer test;[26] Tender medially"

April 17, 2017: "PE – left knee with some swelling; No frank effusion; + crepitus"

July 20, 2017: "PE – left knee with crepitus, tenderness at patella; Some pain medially on palpation"

January 4, 2018: "PE – left knee with small effusion, swelling of medial bursa"

123. Patient E's chart for the period reviewed showed no treatments from orthopedics or pain management services.

124. During the Patient E period reviewed, Respondent made no recommendations for physical or acupuncture therapy, or for chiropractic adjustments.

125. During the Patient E period reviewed, Respondent recommended no medications like NSAIDS or tricyclic antidepressants or anti-seizure medications, cognitive behavior therapies or topical therapies. Patient E's pain was managed entirely by Respondent, based on narcotic therapy.

126. Patient E's chart for the period reviewed showed drug toxicology testing on two occasions, namely, July 2016 and April 2017.

127. Respondent's progress notes for Patient E are sparsely notated. No vital signs were recorded in Patient E's chart throughout the period reviewed, and there is no documentation of the "five A's" of chronic pain management. The chart contains no CURES reports.

Patient F:

128. Patient F is a male minor child born in September 2010.

129. On or about May 17, 2016, the mother of Patient F emailed Respondent, introducing herself and explaining that she was looking for a doctor "to help [her] with getting a child a medical exemption ..." Between on or about May 17, 2016, and August 23, 2016, Patient F's mother and responded emailed back and forth regarding a vaccine exemption for Patient F and

[26] Negative anterior drawer test. The anterior drawer test is a physical examination that may be used to test the stability of the knee's anterior cruciate ligament (ACL). If the anterior drawer test is positive, and the ligaments are not as supportive as they should be, a person may need a variety of treatments based on the severity of their injuries.

obtaining what Respondent considered to be relevant family history for this exemption. Respondent advised Patient F's mother to "look at [Respondent's] webpage [on vaccine exemptions] for ideas."

130. Finally, by email dated August 23, 2016, Respondent wrote to Patient F's mother:

> "Yes! Fantastic! That is exactly what we needed !!!
>
> 1. Dad – food allergies, psoriasis (dad wrote his own letter) – documented ([grandmother] confirmed)
> 2. Mom – food allergies - documented
> 3. [Patient F] – eczema/rash, food allergies – DOCUMENTED
> 4. Aunt … - psoriasis – documented
> 5. Cousin – celiac"
>
> I have put you down as qualified and documented. …"

Apart from Patient F, the family members' medical histories are "documented" only by letters or reports from family members. Their "food allergies" are not formal diagnoses of allergy, but rather that the family gets "bad physical side effects after eating wheat[,] dairy and soy." Patient F's father reportedly "had a bad reaction to a vaccine when he was a kid… [H]is mother said he had mini seizures after he got vaccinated." Patient F's mother informed Respondent that she has "had digestive issues my whole life due to food allergies."

131. Patient F suffered from asthma, and was said by his mother to get "chronic coughs any time he eats certain foods… He also gets eczema and a skin rash around his mouth." Respondent's chart for (the then almost six year old) Patient F does not include any record or note regarding whether or not he had received any prior vaccines.

132. Respondent saw Patient F at one visit, a group visit, on or about August 25, 2016. A physical exam was documented in Patient F's chart with a checklist, and "const" (constitutional", eyes, "ENT/mouth" and neck were all checked off as "WNL." A superbill for this visit included detailed visit (99203) and the family was charged $120.

133. Respondent prepared a document dated August 26, 2016, providing Patient F with a permanent medical exemption from all vaccines on the Center for Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

> [Patient F] DOB 9/[xx]/10 has a strong family history of hyperimmune conditions like food allergies, and autoimmune diseases like Celiac and Psoriasis in multiple generations. Given this level of immune dysfunction in the family history, I

feel he is at a high risk of adverse reaction to vaccines. If there is an imminent medical threat in the community we can consider a single vaccine in a controlled medical environment, however, the benefits to him and the community must greatly outweigh his very real personal risk. I would recommend skin testing to the vaccine and all its additives prior to injection. This medical exemption for vaccines is permanent. It includes, but is not limited to, DtaP [*sic*], TdaP, Polio, Varicella, MMR, Hep B and A, HPV, HiB, Flu and Meningitis and includes all current vaccines on the CDC recommended vaccine list and any future vaccines placed on the list.

134. Respondent maintains a website with a page dedicated to vaccines. On it, she makes statements that include the following:

> ... The standard vaccine schedule is now being disputed by many pediatricians, including yours truly, because it recommends too many shots all at once, especially at the one year mark, which is when the measles vaccine (MMR) is first given. ... Children with hyper immune systems, such as those with eczema or food allergies, do not handle that many shots well. Because of this, many pediatricians are advocating for a slower schedule. ...
>
> I feel [the Hepatitis B vaccine] is not needed [for newborns or infants] until they are at risk of being bitten - like at daycare with toddlers - or as a teen. If you test negative for Hepatitis B, then you can choose to do the standard schedule or you can do them at 2 years old or as a teen. ...
>
> A very interesting fact is that [the Chicken Pox vaccine] may have eliminated a natural immunity boost against Shingles. . ... Without children getting chicken pox, parents and grandparents are now getting shingles. [The Chicken Pox] vaccine created the need for [the Shingles] vaccine.
>
> [The HPV[27] vaccine] is now recommended for boys, since they transmit to the girls, but I feel this is overstepping the parameters of the vaccine. ...
>
> One last important point: Unvaccinated children are really only a risk to other unvaccinated children, and only if ill...

135. In fact, Respondent's statement that children cannot handle multiple immunizations is false and unsupported by any data. By not recommending the Heptatitis B vaccine routinely, Respondent ignores that there are Hepatitis B cases that are cryptogenic (that is, of uncertain origin, or no source is identified). Shingles is actually prevented by the primary chicken pox vaccine, and Respondent's lack of support for HPV vaccinations for boys shows she does not understand HPV transmission and the risk of oropharyngeal cancer to both sexes.

136. Respondent's rationale for providing the vaccine exemption to Patient F is that, in her view, patients with family members with asthma, allergies or psoriasis will be at risk of "overreaction" to vaccinations. In fact, patients with allergies (for instance, asthma or eczema)

[27] Human papillomavirus.

are at greater risk from the vaccine preventable diseases (for instance, influenza in the case of patients with asthma, and varicella in the case of patients with eczema), so that vaccine is highly recommended in these patients, not contraindicated or cautioned against.

137. Providing Patient F with an exemption from all vaccinations, current and future, on this basis was not consistent with, and was in direct opposition to, the recommendations of the CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies.

138. Respondent's recommendation of "skin testing to the vaccine and all its additives prior to [vaccination]" is not a reasonable or scientific approach to managing vaccination in a child with a history of allergies.

Patient G:

139. Patient G is a male minor child born in October 2005.

140. On or about January 21, 2017, Patient G's mother wrote to Respondent, inquiring about a vaccine exemption for Patient G, then 11 years old, who suffered from asthma and allergies.

141. On the same day, Respondent replied:

> "Unfortunately, asthma requires more vaccines ... not fewer... However, if we can prove the immune systems of many in the family are over active, then we can show that it is likely he inherited the problem also, as evidenced by his asthma, and therefore he is more likely to have a bad reaction to a vaccine..."

142. Respondent then referred Patient G's mother to her webpage on vaccine exemptions:

> "[S]ee the list of all the diseases that can help him qualify. ... Then email me who has what diseases in the family and their documentation. I am doing all preliminary qualifying and gathering of documents by email, and only schedule a one-time Group appointment when I have all documentation..."

143. Finally, Respondent found there to be sufficient documentation, and noted in Patient G's chart:

1. [Patient G] – allergies – DOCUMENTED
2. [Grandmother] – asthma – DOCUMENTED
3. [Aunt] – Hashimotos – DOCUMENTED
4. [Grandfather] – type 1 [diabetes mellitus] – DOCUMENTED

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144. On or about February 8, 2017, Respondent wrote:

> "GOOD JOB!
> I have put you down as qualified and documented!
> My next Group visit for the medical exemptions will be in March. I will email with details soon.
> If you require something for school before that time, let me know and I can write a promise of appointment letter."

145. Patient G's mother wrote to Respondent on or about February 9, 2017, saying she was impatient for an appointment earlier than March. Respondent explained that she had "a very busy regular practice, and 75 people ahead of [Patient G] on the list." The "group appointment" allowed Respondent to see thirty people in one day. Respondent then forwarded a "promise of an exemption" letter for Patient G (dated February 7, 2017) to his mother. The letter, addressed "To whom it may concern," stated the following:

> [Patient G] has an appointment in March for an evaluation of his immunization status. I certify that he is fully qualified per California law SB277 for a medical exemption to vaccines. I have full medical documentation in my possession upon which I base this determination. I am currently waiting for my schedule to accommodate his appointment. The appointment is guaranteed, at which time I will formally write the medical exemption according to law and dept. of Public Health regulations. The exemption will be permanent and include DtaP [*sic*], TdaP, MMR, Polio, Varicella, Hib, PCV, Meningitis and Hepatitis A and B. Thank you for understanding the scheduling difficulties of this time of year, especially with the new law in place. Please contact me if you have further questions.

146. Respondent did not obtain or review Patient G's past medical records, including previous vaccine records.

147. Respondent saw Patient G at one visit, on or about March 7, 2017, at a group visit. A physical exam was documented in Patient G's chart with a checklist, and "const" (constitutional", eyes, "ENT/mouth" and neck, were all checked off as "WNL." A superbill for this visit included detailed visit (99203) and the family was charged $120.

148. On or about March 7, 2017, Respondent prepared a document providing Patient G with a permanent medical exemption from all vaccines on the Center for Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

> [Patient G] DOB 10/[xx]/05 has a very strong family history of hyperimmune reactions, and autoimmune diseases like Hashimotos Disease. Given this, I feel he is at a high risk of adverse reaction to vaccines. If there is an imminent medical threat in

> the community we can consider a single vaccine in a controlled medical environment; however, the benefits to him and the community must greatly outweigh his very real personal risk. This medical exemption for vaccines is permanent. It includes, but is not limited to, DtaP[28] [*sic*], TdaP, Polio, Varicella, MMR, Hep B and A, HIB, PCV, HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC list.

149. Respondent's rationale for providing the vaccine exemption to Patient G is that, in her view, patients with family members with "a family history of overreactions ... and autoimmune diseases" placed Patient G at higher risk of an adverse reaction to vaccines. In fact, a family history of allergic or autoimmune conditions does not make a vaccine reaction more likely in the child.

150. Providing Patient G with an exemption from all vaccinations, current and future, on this basis was not consistent with, and was in direct opposition to, the recommendations of the CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies.

Patients H and I:

151. Patient H is a female minor child born in January 2010. Her sibling, Patient I, is a male minor child born in August 2013.

152. On or about December 5, 2018, the siblings' mother emailed Respondent in connection with obtaining vaccine exemptions for Patient H and Patient I. She provided documentation in substantiation of the children's "qualifying disease," namely, asthma.

153. On or about December 17, 2018, Respondent responded, "Good work!" In her email, she informed the mother that the next "Group Visit" appointment would be on January 9, 2019, and that "one person receiving the exemption should be present. If a child or a family, then only one parent and one child needs to be present." In addition, if "something for school" was required before the appointment, Respondent offered to write a "promise of appointment letter."

154. Respondent saw Patient H and Patient I at one visit, on or about January 9, 2019, at a group visit. At an interview during the Board's investigation into this matter, Respondent

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[28] Due to his age, Patient G was not eligible for DTaP or Hib. These are not administered to children older than 7 and 4 years of age, respectively. Further, if Patient G had already received some vaccines, he may not have needed to receive additional vaccines for MMR, varicella, or hepatitis A and B.

explained that she used the children's asthma action plans and their mother's inhaler prescription to verify the "over reactive" immune system of Patient H and Patient I.

155. Respondent's chart for Patient H contains a documented physical exam with a checklist that has "const" (constitutional), eyes, "ENT/mouth" and neck, all checked off as being "WNL." No vital signs are recorded. A superbill for this group visit indicates it was a "detailed" visit for which the family was charged $120. Respondent's chart for Patient I contains an almost identical checklist, with additional check marks at "Resp" and "CV." No vital signs are recorded. A superbill for this group visit indicates it was a "minimal" visit for which the family was again charged $120.

156. Respondent did not obtain or review Patient H or Patient I's past medical records.

157. In fact, Patient H's medical records from her primary care provider show that Patient H had received multiple prior vaccines and her primary care physician did not regard her as having any medical condition that would warrant medical exemption.

158. A review of Patient I's medical records from his primary care provider show that, at two years of age, he had a hospital admission for RSV (Respiratory Syncytial Virus, a common respiratory virus) with asthma exacerbation. At four years of age, he had a pustule in his nostril that cultured positive for MRSA (methicillin-resistant Staphylococcus aureus, a type of bacteria that is resistant to several antibiotics). His primary care physician noted in his chart that she recommended Patient I receive vaccines consistent with AAP and CDC guidelines.

159. It is well established that children with asthma are at particularly high risk of complications from influenza infection, including pneumonia, respiratory failure, and even death. Additionally, Patient I – due to his MRSA colonization – was at increased risk of infectious complications (MRSA pneumonia) if infected with influenza, which constituted an additional reason to make sure he was protected from seasonal influenza.

160. On or about January 9, 2019, Respondent prepared a document providing Patient H and Patient I with identical permanent medical exemptions from all vaccines on the Center for Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

> [Patient name and date of birth] has a strong family history of hyperimmune conditions like anaphylaxis in multiple generations. Given the level of immune dysfunction in the family, I feel [s]he is at higher risk of adverse reaction to vaccines. If there is an imminent medical threat in the community we can consider a single vaccine in a controlled medical environment; however, the benefits to [her/him] and the community must greatly outweigh [her/his] very real personal risk. This medical exemption for vaccines is permanent. It includes, but is not limited to, DtaP/TdaP/Td/dT, Polio, MMR, Varicella, Hep B and A, HIB, PCV, HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC recommended vaccine list and any future vaccines placed on the list.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

161. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of Patient A, Patient B, Patient C, Patient D, Patient F, Patient G, Patient H and Patient I, as more particularly alleged hereinafter:

Patient A:

162. Paragraphs 44 through 58, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

163. Respondent committed gross negligence in her care and treatment of Patient A in granting a permanent vaccine exemption for Patient A based on a remote and irrelevant family medical history.

Patient B:

164. Paragraphs 44, and 59 through 76, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

165. Respondent committed gross negligence in her initiation and/or monitoring of Patient B's chronic opiate pain medications, including, but not limited to, her failure to recognize Patient B's opiate tolerance sooner, her inadequate clinical assessment(s) of Patient B's pain and functionality, the inadequate tapering process, Respondent's failure to prescribe naloxone sooner, and her prescribing opiates to Patient B with an MEDD in excess of 1000 mg.

166. Respondent committed gross negligence by failing to maintain adequate and accurate records of her care and treatment of Patient B.

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Patient C:

167. Paragraphs 44, and 77 through 103, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

168. Respondent committed gross negligence in her initiation and/or monitoring of Patient C's chronic opiate pain medications, including, but not limited to, her lack of addiction risk assessment, lack of a multi-disciplinary pain management approach, fast escalation of narcotic dosage, failure to recognize opiate tolerance, failure to recognize opioid addiction, failure to taper down the opiate dosage, and/or lack of routine toxicology drug testing and CURES consultations.

Patient D:

169. Paragraphs 44, and 104 through 116, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

170. Respondent committed gross negligence in her initiation and/or monitoring of Patient D's chronic opiate pain medications, including, but not limited to, an excessively high narcotic dosage and lack of tapering, her failure to recognize Patient D's opiate tolerance and failure to consult pain management in a complicated patient, lack of addiction risk assessment, and/or minimal drug toxicology testing and CURES consultations.

Patient F:

171. Paragraphs 44, and 128 through 138, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

172. Respondent committed gross negligence in her care and treatment of Patient F in granting a permanent vaccine exemption for Patient F based on a remote and irrelevant family medical history.

Patient G:

173. Paragraphs 44, and 139 through 150, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

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174. Respondent committed gross negligence in her care and treatment of Patient G in granting a permanent vaccine exemption for Patient G based on a remote and irrelevant family medical history.

Patients H and I:

175. Paragraphs 44, and 151 through 160, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

176. Respondent committed gross negligence in her care and treatment of Patient H in granting a permanent vaccine exemption for Patient H based on an irrelevant family medical history.

177. Respondent committed gross negligence in her care and treatment of Patient I in granting a permanent vaccine exemption for Patient I based on an irrelevant family medical history.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

178. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, Patient G, Patient H and Patient I, as more particularly alleged hereinafter:

179. Paragraphs 44 through 177, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

180. Respondent also committed the following repeated negligent acts in her care and treatment of Patient B, Patient D, and Patient E:

(a) Respondent failed to consider and/or employ non-opiate treatments in conjunction with opiate management of Patient B.

(b) Respondent failed to obtain diagnostic evaluation of Patient C's chronic orthopedic pains and failed to make an adequate attempt at using non-opiate treatments or therapies to reduce Patient C's dependency on narcotics during the three-year period reviewed;

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(c) Respondent failed to ensure that Patient C received appropriate psychiatric care and management by mental health experts before trying low dose alprazolam therapy (in combination with Patient C's long term opiate therapy), and/or failed to taper Patient C's opiate dosage in light of his worsening anxiety and panic attacks (which are often warning signs of opiate withdrawal and physical dependency);

(d) Respondent failed to maintain adequate and accurate documentation of her care and treatment of Patient C.

(e) Respondent failed to offer concurrent non-opiate therapy to Patient D to attempt to reduce her dependency on high dose opiates;

(f) Respondent failed to ensure that Patient D received appropriate psychiatric care and management by mental health experts and/or prescribed alprazolam 6 mg daily combined with Patient D's long-term 720 mg MEDD, placing Patient D at risk for accidental overdose;

(g) Respondent failed to properly monitor Patient D's Adderall therapy;

(h) Respondent failed to maintain adequate and accurate documentation of her care and treatment of Patient D.

(i) Respondent failed to provide non-opiate treatment to Patient E and prescribed high dose narcotics without performing a thorough evaluation of Patient E's knee and knee pains and/or without a detailed functional assessment;

(j) Respondent failed to conduct a thorough and/or adequate risk assessment and monitoring of the therapeutic efficacy of the narcotic medications she prescribed to Patient E;

(k) Respondent failed to maintain adequate and accurate medical records of her care and treatment of Patient E.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

181. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that she demonstrated incompetence in her care and treatment of Patient A, Patient F, Patient G, Patient H and Patient I, as more particularly alleged in paragraphs 44 through 58, and 128 through 160 above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

182. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records in her care and treatment of Patient B, Patient C, Patient D, and Patient E, as more particularly alleged in paragraphs 59 through 127, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

183. Respondent is further subject to disciplinary action in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 44 through 182, above, which are hereby realleged and incorporated by this 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 A 71646, issued to Respondent Tara Alaina Zandvliet, M.D.;

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

3. Ordering Respondent Tara Alaina Zandvliet, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: SEP 0 9 2021

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

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

In the Matter of the Second Amended Accusation Against: **TARA ALAINA ZANDVLIET, M.D.** **2991 Kalmia St.** **San Diego, CA 92104** **Physician's and Surgeon's Certificate No. A 71646** Respondent.	Case No. 800-2017-00305630 OAH No. 2020120905

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on _____.

It is so ORDERED _____.

_____
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

> the community we can consider a single vaccine in a controlled medical environment; however, the benefits to him and the community must greatly outweigh his very real personal risk. This medical exemption for vaccines is permanent. It includes, but is not limited to, DtaP[28] [*sic*], TdaP, Polio, Varicella, MMR, Hep B and A, HIB, PCV, HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC list.

149. Respondent's rationale for providing the vaccine exemption to Patient G is that, in her view, patients with family members with "a family history of overreactions ... and autoimmune diseases" placed Patient G at higher risk of an adverse reaction to vaccines. In fact, a family history of allergic or autoimmune conditions does not make a vaccine reaction more likely in the child.

150. Providing Patient G with an exemption from all vaccinations, current and future, on this basis was not consistent with, and was in direct opposition to, the recommendations of the CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies.

Patients H and I:

151. Patient H is a female minor child born in January 2010. Her sibling, Patient I, is a male minor child born in August 2013.

152. On or about December 5, 2018, the siblings' mother emailed Respondent in connection with obtaining vaccine exemptions for Patient H and Patient I. She provided documentation in substantiation of the children's "qualifying disease," namely, asthma.

153. On or about December 17, 2018, Respondent responded, "Good work!" In her email, she informed the mother that the next "Group Visit" appointment would be on January 9, 2019, and that "one person receiving the exemption should be present. If a child or a family, then only one parent and one child needs to be present." In addition, if "something for school" was required before the appointment, Respondent offered to write a "promise of appointment letter."

154. Respondent saw Patient H and Patient I at one visit, on or about January 9, 2019, at a group visit. At an interview during the Board's investigation into this matter, Respondent

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[28] Due to his age, Patient G was not eligible for DTaP or Hib. These are not administered to children older than 7 and 4 years of age, respectively. Further, if Patient G had already received some vaccines, he may not have needed to receive additional vaccines for MMR, varicella, or hepatitis A and B.

explained that she used the children's asthma action plans and their mother's inhaler prescription to verify the "over reactive" immune system of Patient H and Patient I.

155. Respondent's chart for Patient H contains a documented physical exam with a checklist that has "const" (constitutional), eyes, "ENT/mouth" and neck, all checked off as being "WNL." No vital signs are recorded. A superbill for this group visit indicates it was a "detailed" visit for which the family was charged $120. Respondent's chart for Patient I contains an almost identical checklist, with additional check marks at "Resp" and "CV." No vital signs are recorded. A superbill for this group visit indicates it was a "minimal" visit for which the family was again charged $120.

156. Respondent did not obtain or review Patient H or Patient I's past medical records.

157. In fact, Patient H's medical records from her primary care provider show that Patient H had received multiple prior vaccines and her primary care physician did not regard her as having any medical condition that would warrant medical exemption.

158. A review of Patient I's medical records from his primary care provider show that, at two years of age, he had a hospital admission for RSV (Respiratory Syncytial Virus, a common respiratory virus) with asthma exacerbation. At four years of age, he had a pustule in his nostril that cultured positive for MRSA (methicillin-resistant Staphylococcus aureus, a type of bacteria that is resistant to several antibiotics). His primary care physician noted in his chart that she recommended Patient I receive vaccines consistent with AAP and CDC guidelines.

159. It is well established that children with asthma are at particularly high risk of complications from influenza infection, including pneumonia, respiratory failure, and even death. Additionally, Patient I – due to his MRSA colonization – was at increased risk of infectious complications (MRSA pneumonia) if infected with influenza, which constituted an additional reason to make sure he was protected from seasonal influenza.

160. On or about January 9, 2019, Respondent prepared a document providing Patient H and Patient I with identical permanent medical exemptions from all vaccines on the Center for Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

> [Patient name and date of birth] has a strong family history of hyperimmune conditions like anaphylaxis in multiple generations. Given the level of immune dysfunction in the family, I feel [s]he is at higher risk of adverse reaction to vaccines. If there is an imminent medical threat in the community we can consider a single vaccine in a controlled medical environment; however, the benefits to [her/him] and the community must greatly outweigh [her/his] very real personal risk. This medical exemption for vaccines is permanent. It includes, but is not limited to, DtaP/TdaP/Td/dT, Polio, MMR, Varicella, Hep B and A, HIB, PCV, HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC recommended vaccine list and any future vaccines placed on the list.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

161. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of Patient A, Patient B, Patient C, Patient D, Patient F, Patient G, Patient H and Patient I, as more particularly alleged hereinafter:

Patient A:

162. Paragraphs 44 through 58, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

163. Respondent committed gross negligence in her care and treatment of Patient A in granting a permanent vaccine exemption for Patient A based on a remote and irrelevant family medical history.

Patient B:

164. Paragraphs 44, and 59 through 76, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

165. Respondent committed gross negligence in her initiation and/or monitoring of Patient B's chronic opiate pain medications, including, but not limited to, her failure to recognize Patient B's opiate tolerance sooner, her inadequate clinical assessment(s) of Patient B's pain and functionality, the inadequate tapering process, Respondent's failure to prescribe naloxone sooner, and her prescribing opiates to Patient B with an MEDD in excess of 1000 mg.

166. Respondent committed gross negligence by failing to maintain adequate and accurate records of her care and treatment of Patient B.

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Patient C:

167. Paragraphs 44, and 77 through 103, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

168. Respondent committed gross negligence in her initiation and/or monitoring of Patient C's chronic opiate pain medications, including, but not limited to, her lack of addiction risk assessment, lack of a multi-disciplinary pain management approach, fast escalation of narcotic dosage, failure to recognize opiate tolerance, failure to recognize opioid addiction, failure to taper down the opiate dosage, and/or lack of routine toxicology drug testing and CURES consultations.

Patient D:

169. Paragraphs 44, and 104 through 116, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

170. Respondent committed gross negligence in her initiation and/or monitoring of Patient D's chronic opiate pain medications, including, but not limited to, an excessively high narcotic dosage and lack of tapering, her failure to recognize Patient D's opiate tolerance and failure to consult pain management in a complicated patient, lack of addiction risk assessment, and/or minimal drug toxicology testing and CURES consultations.

Patient F:

171. Paragraphs 44, and 128 through 138, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

172. Respondent committed gross negligence in her care and treatment of Patient F in granting a permanent vaccine exemption for Patient F based on a remote and irrelevant family medical history.

Patient G:

173. Paragraphs 44, and 139 through 150, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

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174. Respondent committed gross negligence in her care and treatment of Patient G in granting a permanent vaccine exemption for Patient G based on a remote and irrelevant family medical history.

Patients H and I:

175. Paragraphs 44, and 151 through 160, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

176. Respondent committed gross negligence in her care and treatment of Patient H in granting a permanent vaccine exemption for Patient H based on an irrelevant family medical history.

177. Respondent committed gross negligence in her care and treatment of Patient I in granting a permanent vaccine exemption for Patient I based on an irrelevant family medical history.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

178. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, Patient F, Patient G, Patient H and Patient I, as more particularly alleged hereinafter:

179. Paragraphs 44 through 177, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

180. Respondent also committed the following repeated negligent acts in her care and treatment of Patient B, Patient D, and Patient E:

(a) Respondent failed to consider and/or employ non-opiate treatments in conjunction with opiate management of Patient B.

(b) Respondent failed to obtain diagnostic evaluation of Patient C's chronic orthopedic pains and failed to make an adequate attempt at using non-opiate treatments or therapies to reduce Patient C's dependency on narcotics during the three-year period reviewed;

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(c) Respondent failed to ensure that Patient C received appropriate psychiatric care and management by mental health experts before trying low dose alprazolam therapy (in combination with Patient C's long term opiate therapy), and/or failed to taper Patient C's opiate dosage in light of his worsening anxiety and panic attacks (which are often warning signs of opiate withdrawal and physical dependency);

(d) Respondent failed to maintain adequate and accurate documentation of her care and treatment of Patient C.

(e) Respondent failed to offer concurrent non-opiate therapy to Patient D to attempt to reduce her dependency on high dose opiates;

(f) Respondent failed to ensure that Patient D received appropriate psychiatric care and management by mental health experts and/or prescribed alprazolam 6 mg daily combined with Patient D's long-term 720 mg MEDD, placing Patient D at risk for accidental overdose;

(g) Respondent failed to properly monitor Patient D's Adderall therapy;

(h) Respondent failed to maintain adequate and accurate documentation of her care and treatment of Patient D.

(i) Respondent failed to provide non-opiate treatment to Patient E and prescribed high dose narcotics without performing a thorough evaluation of Patient E's knee and knee pains and/or without a detailed functional assessment;

(j) Respondent failed to conduct a thorough and/or adequate risk assessment and monitoring of the therapeutic efficacy of the narcotic medications she prescribed to Patient E;

(k) Respondent failed to maintain adequate and accurate medical records of her care and treatment of Patient E.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

181. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that she demonstrated incompetence in her care and treatment of Patient A, Patient F, Patient G, Patient H and Patient I, as more particularly alleged in paragraphs 44 through 58, and 128 through 160 above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

182. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records in her care and treatment of Patient B, Patient C, Patient D, and Patient E, as more particularly alleged in paragraphs 59 through 127, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

183. Respondent is further subject to disciplinary action in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 44 through 182, above, which are hereby realleged and incorporated by this 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 A 71646, issued to Respondent Tara Alaina Zandvliet, M.D.;

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

3. Ordering Respondent Tara Alaina Zandvliet, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: SEP 09 2021

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