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

In the Matter of the First Amended Accusation Against: **Athanasios Ssettimba Magimbi, M.D.** **Physician's and Surgeon's Certificate No. A 76322** **Respondent.**	**Case No.: 800-2019-053989**

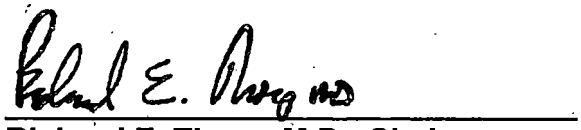
DECISION

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

This Decision shall become effective at 5:00 p.m. on October 14, 2022.

IT IS SO ORDERED: September 14, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the First Amended Accusation Against: **ATHANASIOS SSETTIMBA MAGIMBI, M.D.** **1530 Bessie Ave., Ste. 105** **Tracy, CA 95376-3080** **Physician's and Surgeon's Certificate No. A 76322** Respondent.	Case No. 800-2019-053989 OAH No. 2021060332 **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 Ryan J. McEwan, Deputy Attorney General.

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2. Respondent Athanasios Ssettimba Magimbi, M.D. (Respondent) is represented in this proceeding by attorney Nicole D. Hendrickson, Esq. whose address is: 655 University Avenue, Suite 119, Sacramento, CA 95825.

3. On or about August 22, 2001, the Board issued Physician's and Surgeon's Certificate No. A 76322 to Athanasios Ssettimba Magimbi, 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 Accusation No. 800-2019-053989, and will expire on February 28, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-053989 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 19, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. The First Amended Accusation was filed and served on Respondent on April 4, 2022.

5. A copy of the First Amended Accusation No. 800-2019-053989 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2019-053989. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2019-053989, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2019-053989, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 76322 to disciplinary action.

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

CONTINGENCY

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

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2019-053989 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 76322 issued to Respondent Athanasios Ssettimba Magimbi, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions:

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

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

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

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

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

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

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

this Decision.

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

4. 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(s), 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.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $4,096.25 (four thousand ninety-six dollars and twenty-five cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by respondent to the Board.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs.

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no

circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2019-053989 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Nicole D. Hendrickson, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2022-04-14

Athanasios Magimbi

ATHANASIOS SSETTIMBA MAGIMBI, M.D.
Respondent

I have read and fully discussed with Respondent Athanasios Ssettimba Magimbi, 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: 4/18/2022

Nicole Hendrickson

NICOLE D. HENDRICKSON, 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: 4/19/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

RYAN J. MCEWAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-053989

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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 First Amended Accusation Against: **ATHANASIOS SSETTIMBA MAGIMBI, M.D.** **1530 Bessie Ave., Ste. 105** **Tracy, CA 95376-3080** **Physician's and Surgeon's Certificate No. A 76322,** Respondent.	Case No. 800-2019-053989 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about August 22, 2001, the Board issued Physician's and Surgeon's Certificate No. A 76322 to Athanasios Ssettimba Magimbi, 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 February 28, 2023, unless renewed.

JURISDICTION

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

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

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.

"...

"(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.

"..."

6. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical conduct of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. 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."

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.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(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."

COST RECOVERY

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

DEFINITIONS

11. **Alprazolam** (generic name for the drug Xanax) is a short-acting benzodiazepine used to treat anxiety, and is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d).

12. **Carisoprodol** (generic name for the drug Soma) is a centrally acting skeletal muscle relaxant. On January 11, 2012, carisoprodol was classified a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Code section 4022.

13. **Fentanyl** (generic name for the drug Duragesic) is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long-term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (c).

14. **Hydrocodone bitartrate with acetaminophen** (generic name for the drugs Vicodin, Norco, and Lortab) is an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). On October 6, 2014, hydrocodone combination products were reclassified as Schedule II controlled substances. Hydrocodone with acetaminophen is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

15. **Hydromorphone hydrochloride** (generic name for the drug Dilaudid) is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

16. **Levorphanol tartrate** is a potent opioid analgesic used to treat moderate to severe pain. It is a high-risk drug for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Levorphanol tartrate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Levorphanol tartrate is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (c).

17. **Methadone** (generic name for the drug Symoron) is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Code section 4022.

18. **Morphine sulfate** (generic name for the drugs Kadian, MS Contin, and MorphaBond ER) is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine sulfate dissolves readily in water and body fluids, creating an immediate release. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022.

19. **Oxycodone** (generic name for Oxycontin, Roxicodone, and Oxecta) is a short-acting opioid analgesic used to treat moderate to severe pain. It is a high-risk drug for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

20. **Oxymorphone** (generic name for Opana) is an opioid analgesic used to treat moderate to severe pain. It is a high-risk drug for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxymorphone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxymorphone is a dangerous drug pursuant to Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

21. **Tapentadol** (generic name for Nucynta) is an opioid analgesic used to treat moderate to severe pain. It is a high -risk drug for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Tapentadol is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Tapentadol is a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent's license is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that he committed repeated negligent acts during the care and treatment of Patients A, B, C, D, E, and F.[2] The circumstances are as follows:

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[2] Patient names are omitted to protect privacy. They will be provided in discovery.

23. Respondent is a physician and surgeon, who at all relevant times to the charges brought herein worked at Chronic Pain Consultants in Tracy, California.

Patient A

24. Patient A is a 54-year-old female who first sought pain management treatment from Respondent in or around 2006 related to pain secondary to peripheral neuropathy. Available patient records indicate the possible etiology of these pain symptoms to be secondary to septicemia. Other diagnoses include cervicalgia and degenerative spondylosis of the cervical spine. In 2019, Respondent began documenting "chronic back pain" as the reason for Patient A's office visits.

25. Patient records and the CURES database indicate that Respondent regularly prescribed oxycodone and methadone to Patient A. For example, in the documentation for a visit on March 31, 2017, Respondent documented Patient A's medications as "[m]ethadone 10 mg 3 tablets by mouth three times a day" and "[o]xycodone 15 mg one tablet by mouth three times a day as needed for breakthrough." Respondent documented, "A total of 335 morphine milligram equivalent dose of pain medications. A situation where we have reaches [sic] the absolute maximum of the opioid that we can use."[3] The CURES database shows that, from October 30, 2016 through October 30, 2019, Respondent prescribed and Patient A filled identical (or nearly identical) prescriptions to the March 2017 visit on a monthly basis.

26. From on or about October 30, 2016, through December 31, 2016, medical records show that Respondent did not see Patient A for any visits; although, he did see Patient A on or about October 27, 2016. During that time, the CURES database indicates that Respondent wrote and Patient A filled: 2 prescriptions for methadone 10 mg for a total of 540 tablets; and 2 prescriptions for oxycodone 15 mg for a total of 240 tablets.

27. From on or about January 1, 2017, through December 31, 2017, medical records show that Respondent saw Patient A for approximately two visits. During that time, the CURES

[3] The Centers for Disease Control and Prevention (CDC) recommends that clinicians avoid increasing prescribed opiates beyond 90 MME per day. Doses above 50 MME per day confer an increased risk of overdose of at least twice that of a dose less than 20 MME per day. The CDC states that higher dosages have not been shown to reduce pain over the long-term and that higher opioid dosages place the patient at higher risk of overdose death.

database indicates that Respondent wrote and Patient A filled: 10 prescriptions for methadone 10 mg for a total of 2,970 tablets; and 12 prescriptions for oxycodone 15 mg for a total of 1,440 tablets.

28. From on or about January 1, 2018, through December 31, 2018, medical records show that Respondent saw Patient A for approximately one visit. During that time, the CURES database indicates that Respondent wrote and Patient A filled: 13 prescriptions for methadone 10 mg for a total of 3,510 tablets; and 13 prescriptions for oxycodone 15 mg for a total of 1,560 tablets.

29. From on or about January 1, 2019, through October 30, 2019, medical records show that Respondent saw Patient A for approximately two visits. During that time, the CURES database indicates that Respondent wrote and Patient A filled: 7 prescriptions for methadone 10 mg for a total of 1,877 tablets; 2 prescriptions for methadone 5 mg for a total of 1,080 tablets; and 8 prescriptions for oxycodone 15 mg for a total of 960 tablets.

30. Despite the regularity of writing opioid prescriptions for Patient A, Respondent did not regularly see or examine the patient to conduct a proper ongoing assessment or periodic review of Patient A's opioid management. Indeed, there are no visits documented between the visits on June 22, 2017, and June 20, 2018. At the former visit, Respondent documented "follow-up" as "awaiting for psychology evaluation for the placement of the intrathecal pump and the authorization by the patient's insurance that may follow." At the latter visit, approximately a year later, there is no mention of the intrathecal pump. After the June 20, 2018 visit, Respondent did not document another visit with Patient A until July 22, 2019. As noted above, Patient A continued to fill the same monthly prescriptions given by Respondent throughout this time.

31. During an interview with Board investigators on June 18, 2020 (the "Board Interview"), Respondent acknowledged that, during the June 2018 – July 2019 timeframe, he continued to prescribe high-dose opioids to Patient A even though he did not see the patient. Respondent stated that Patient A called the office to get her medications. He further acknowledged that there were no records of those communications.

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32. Respondent committed negligence in his care and treatment of Patient A, which included, but is not limited to, the following:

A. Respondent failed to perform periodic reviews of Patient A's opioid management for extensive periods between June 2017 and July 2019.

B. Respondent failed to keep records of his care and treatment of Patient A for extensive periods between June 2017 and July 2019.

Patient B

33. Patient B is a 42-year-old female who first sought pain management treatment from Respondent as early as 2008 for complaints of temporomandibular joint dysfunction ("TMJ") as well as back pain. Additional diagnoses include degenerative spondylosis of the lumbar spine, lumbago, lumbar radiculopathy, and sacrioliitis. Respondent saw Patient B for regular pain management visits and occasionally performed steroid injections and back ablation procedures.

34. Patient records and the CURES database indicate that Respondent regularly prescribed Dilaudid and methadone to Patient B. Respondent also periodically prescribed Soma. For example, in the documentation for a visit on July 20, 2017, Respondent documented Patient B's medications as "[m]ethadone 10 mg two tablets by mouth three times a day" and "Dilaudid 8 mg one tablet by mouth four times a day as needed for breakthrough pain" and "Soma 350 mg one tablet by mouth three times a day for two weeks." Respondent documented the treatment plan as follows: "Will provide the patient with Soma for the trip with her family and will keep the dose of opioid at the current level at 305 milligram morphine equivalent." The CURES database shows that, from October 30, 2016 through October 30, 2019, Respondent prescribed and Patient B filled nearly identical Dilaudid and methadone prescriptions to the July 2017 visit on a monthly basis, as well as periodic prescriptions for Soma.

35. During the same time period noted for CURES above, Respondent documented approximately 16 office visits related to Patient B's chronic pain complaints (in addition to documentation for other procedures performed). Although Respondent documented certain portions of Patient B's medical history and a physical examination, Respondent did not include documentation of Patient B's mental health status during any of those visits. In addition,

Respondent prescribed diazepam on three different occasions in 2018—each time for 3 tablets at the 10 mg strength—but did not indicate a reason for the prescription or make any note regarding Patient B's mental health status.

36. During the Board Interview, Respondent noted that Patient B "had some issues" with urine toxicology testing, and that Patient B was "not taking the medication consistently sometimes or running out . . . of medication because she was using more than [she was] prescribed."

37. Patient B's medical records include laboratory reports from urine toxicology screens performed between April 2018 and June 2020, as well as one report from April 2010. On or about April 30, 2010, Patient B's toxicology screen was positive for oxycodone, which was inconsistent with her prescriptions. On or about July 10, 2018, and July 10, 2019, Patient B's toxicology screens were negative for Dilaudid, which was inconsistent with her medications. On four separate occasions between April 2018 and June 2020, Patient B provided samples that triggered the alcohol screen and/or were positive for ethyl alcohol. Respondent did not document a discussion with Patient B concerning these inconsistent test results. Nor did he document a discussion regarding the risk of drinking alcohol while taking opioids. To the contrary, the visit summaries in 2018 repeatedly state that Patient B does not drink alcohol despite three positive tests between April and September of that year.

38. Respondent committed negligence in his care and treatment of Patient B, which included, but is not limited to, the following: failing to document Patient B's mental health status while prescribing opioids on a continuous basis.

Patient C

39. Patient C is a 57-year old female who first sought pain management treatment for chronic low back pain from Respondent on or around August 6, 2018. Respondent documented a lumbar MRI from April 27, 2018, which showed severe central/foraminal nerve root compression. Additional diagnoses include spondylosis with radiculopathy (lumbar region) and chronic thoracic pain.

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40. Patient records and the CURES database indicate that Respondent regularly prescribed opioids to treat Patient C's lumbar stenosis and back pain. Respondent initiated opioid treatment by prescribing levorphanol tartrate 2 mg, 1 tablet every 8 hours. Over the next year, Respondent prescribed several different opioid medications, including fentanyl, hydromorphone, oxycodone, and oxymorphone.

41. On or about August 6, 2018, Respondent saw Patient C for the first time. Respondent documented chronic back pain as the reason for the appointment. Respondent documented the history of present illness by noting that: Patient C has had severe back pain for many years; her pain level was rated 8/10 at the time of visit; her pain increases to 10/10 at its worst, which happens every day; she takes medication for relief; and her sleep is poor and interrupted by pain. Respondent documented her current medications as lyrica, clonazepam, fentanyl, cryselle, diclofenac, and Vitamin D. Respondent documented an anxiety disorder, psoriasis, insomnia, and fibromyalgia for her past medical history. He documented a physical examination and assessed her as having low back pain and other spondylosis with radiculopathy (lumbar region). For treatment, Respondent documented low back pain and that he would start amitiza capsules and levorphanol tartrate tablets. The visit summary did not state any objectives for the treatment plan.

42. Over the next four months, Respondent saw Patient C approximately six times. During that time, Respondent made several medication changes to treat Patient C's pain. For example, on or about August 20, 2018, Respondent documented a visit for "chronic back pain" and to "go over meds." Respondent did not document a history of present illness. He made the same assessments as in the initial visit. For treatment, Respondent simply added that he would start oxycodone and continue levorphanol tartrate. Again, Respondent did not document a reason for these particular medications or adding the oxycodone. Similarly, Respondent documented a visit on November 13, 2018. For current medications, he included hydromorphone and noted that oxycodone had been discontinued. For treatment, Respondent documented that he would continue hydromorphone and start Nuvigil.[4] The CURES database reveals that, approximately one week

[4] Nuvigil (brand name for armodafinil) is a stimulant used to treat sleepiness caused by narcolepsy, shift work sleep disorder, or sleep apnea.

before that visit, Patient C filled prescriptions for 10 tablets of hydromorphone 32 mg and 40 tablets of hydromorphone 8 mg. It is unclear from Respondent's documentation when he decided to switch Patient C's opioid management from oxycodone to hydromorphone. Regardless of when Respondent made that change, he did not document an explanation for it. In the next visit, on or about November 28, 2018, Respondent did not document a history of present illness, and his treatment plan simply states that he would start oxycodone. His assessments included, for the first time, pain in the thoracic spine. At the next visit, on or about December 26, 2018, Respondent started Patient C on levorphanol tartrate (again) and oxymorphone. Again, Respondent did not document an explanation for these changes.

43. On or about January 14, 2019, Respondent noted that Patient C's medication was "suboptimal at this point." He further documented that he would "increase the dose of oxymorphone and see how she does." After increasing her oxymorphone dosage, Respondent continued with the same or similar opioid regimen for the next several months. In 2019, he saw Patient C every two to three months. It appears that Respondent again switched her medication from oxymorphone to oxycodone and back to oxymorphone in the second half of 2019—without explanation in the visit summaries. He also switched Patient C from levorphanol tartrate to fentanyl patches in September 2019 "when she [was] no longer able to get levorphanol."

44. At the onset and throughout Respondent's treatment of Patient C, Respondent did not document a treatment plan or treatment objectives other than listing her medications. Nor did he document explanations for choosing or switching to particular medications. Despite her documented MRI findings and continued pain after receiving regular opioids, Respondent did not document that he had obtained consultations or planned to obtain consultations from other providers—such as a spine surgeon—to help address her painful spinal stenosis.

45. From on or about August 6, 2018, through December 31, 2018, the CURES database indicates that Respondent wrote and Patient C filled: 4 prescriptions for levorphanol tartrate 2 mg for a total of 540 tablets; 4 prescriptions for oxycodone 15 mg for a total of 420 tablets; 1

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prescription for 120 tablets of oxymorphone 10 mg; 1 prescription for 40 tablets of hydromorphone 8 mg; and 1 prescription for 10 tablets of hydromorphone 32 mg.[5]

46. From on or about January 1, 2019, through October 30, 2019, the CURES database indicates that Respondent wrote and Patient C filled: 10 prescriptions for oxymorphone 10 mg for a total of 1,486 tablets; 8 prescriptions for levorphanol tartrate 2 mg for a total of 1,440 tablets; 2 prescriptions for oxycodone 15 mg for a total of 240 tablets; and two prescriptions for fentanyl 75mcg for a total of 20 patches.[6]

47. Respondent committed negligence in his care and treatment of Patient C, which included, but is not limited to, the following:

A. Respondent failed to document a treatment plan and objectives multiple times throughout the course of treatment for Patient C; and

B. Respondent failed to refer Patient C to other providers for consultations, or a surgical evaluation, related to her spinal diagnoses and chronic pain. **Patient D**

48. Patient D is a 56-year-old male who first sought pain management treatment from Respondent in or around November 2013 for complaints of back pain. Additional diagnoses include degenerative spondylosis of the lumbar spine, lumbago, lumbar radiculopathy, chronic bilateral knee pain, and severe elbow pain. Patient D had a history of lumbar laminectomy and later underwent a total knee replacement while under the pain management care of Respondent. Respondent treated Patient D's pain issues with a combination of opioid medication and epidural steroid injections.

49. Patient records and the CURES database indicate that Respondent regularly prescribed Nucynta to Patient D. From approximately December 2016 through April 2017, Respondent prescribed 120 tablets of Nucynta 75 mg per month. In or about May 2017, Respondent increased the dosage to 100 mg while maintaining the same number of tablets. On or

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[5] Respondent also wrote two prescriptions for armodafinil 150 mg for a total of 90 tablets.

[6] Respondent also wrote nine prescriptions for armodafinil 150 mg for a total of 540 tablets; and two prescriptions for modafinil 100 mg for a total of 60 tablets, which is also a stimulant used to treat sleepiness caused by narcolepsy, shift work sleep disorder, or sleep apnea.

about January 26, 2018, Respondent added armodafinil to Patient D's medications to address sleepiness at work. In or around March 2019, following a total knee replacement, Respondent briefly switched Patient D from Nucynta to oxycodone 15 mg tablets, before switching back to Nucynta in May 2019. Respondent continued prescribing 120 tablets of Nucynta 100 mg per month through at least October 12, 2019.

50. From November 26, 2013 through December 30, 2019, Respondent documented approximately 27 office visits, primarily for regular pain management check-ups but also for steroid injections. Respondent typically documented certain portions of Patient D's medical history and physical examination. For example, on or about April 13, 2018, Respondent documented a description of Patient D's current pain complaints as well as a description of a lateral epicondyle injection performed by Respondent. The visit summary, however, does not include documentation of Patient D's psychological function. This is representative of the visit summaries throughout Respondent's care and treatment of Patient D, which are devoid of notes concerning Patient D's mental health status.

51. Respondent committed negligence in his care and treatment of Patient D, which included, but is not limited to, the following: failing to document Patient D's mental health status while prescribing opioids on a continuous basis.

Patient E

52. Patient E is a 79-year old-male who first sought pain management treatment from Respondent on or about August 25, 2015 for back pain. Additional diagnoses include degenerative spondylosis of the cervical and lumbar spine, cervicalgia, lumbago, cervical and lumbar radiculopathy, and shoulder pain. Patient E suffered a stroke in or around Summer 2017.

53. Patient records and the CURES database indicate that Respondent regularly prescribed opioid medications to treat Patient E's symptoms, including a range of medications over the course of treatment such as fentanyl, hydrocodone-acetaminophen, methadone, morphine sulfate, oxycodone, and oxymorphone. For example, on or about November 22, 2016, Patient E filled a prescription for 120 tablets of hydrocodone-acetaminophen 325 mg-10 mg. On or about August 17, 2017, Patient E filled a prescription for 180 tablets of oxycodone 5 mg. In February

2019, Patient E filled prescriptions for 10 patches of fentanyl 12 mcg/1hr and 180 tablets of oxymorphone 10 mg.

54. During Patient E's first visit to Respondent, on or about August 25, 2015, Respondent documented subjective reports of back pain and episodes of numbness over the feet. He reported a physical exam and diagnosed Patient E as follows: "Degenerative spondylosis of the lumbar spine, lumbago and lumbar radiculopathy." Respondent documented the treatment plan as follows: "Will initiate Fentanyl and Hydrocodone/APAP." Respondent did not document Patient E's mental health status or alcohol use at the initial visit.

55. On or about August 9, 2019, Respondent updated his history and physical for Patient E, including a substance abuse history. Respondent did not include an assessment of Patient E's psychological function.

56. Following the initial visit in 2015, Respondent regularly treated Patient E—typically every one or two months—but did not adequately assess Patient E's mental health status. On or about July 13, 2017, Respondent noted that, following a recent stroke, Patient E had been very anxious and had experienced panic attacks. Respondent did not document depression or any other aspects of Patient E's psychological function at that visit. Respondent initiated a prescription for Xanax. Even though Respondent continued to prescribe Xanax at least until October 2018, Respondent never documented any additional notes related to anxiety after the July 2017 visit. In 2019, Respondent made passing references to depression (or antidepressant medication) without making a diagnosis or treatment plan related to it. Despite several years of either no, or very little, documentation related to Patient E's mental health status, Respondent revealed at the Board Interview that Patient E suffers from major depression.

57. Respondent committed negligence in his care and treatment of Patient E, which included, but is not limited to, the following: failing to document Patient E's mental health status while prescribing opioids on a continuous basis.

Patient F

58. Patient F is a 57-year-old male who regularly saw Respondent since at least 2012 for neck, back, and shoulder pain. Patient F's diagnoses include degenerative spondylosis of the

cervical and lumbar spine, cervicalgia, lumbago, and cervical and lumbar radiculopathy, and shoulder pain and arthritis. Respondent saw Patient F for regular pain management visits and performed epidural steroid injections for both the lumbar and cervical spine.

59. Patient records and the CURES database indicate that Respondent regularly prescribed methadone, oxycodone, and Soma. For example, in November 2016, Respondent wrote and Patient F filled prescriptions for 180 tablets of methadone 10 mg, 120 tablets of oxycodone 15 mg, and 60 tablets of Soma 350 mg. The CURES database shows that, from October 30, 2016 through October 30, 2019, Respondent prescribed and Patient F filled nearly identical prescriptions on a monthly basis.

60. Respondent provided documentation of Patient F's visits dating back to March 2012. Although Respondent documented certain portions of Patient F's medical history and a physical examination, Respondent did not include documentation of Patient F's mental health status during any visit. In addition, Respondent did not document Patient F's alcohol use for any visit until March 29, 2018, and not again until August 2, 2019. At those visits, Respondent noted that Patient F drinks socially.

61. Patient F's medical records include laboratory reports from urine toxicology screens performed periodically in 2012, 2018, and 2019. On or about March 15, 2012, Patient F's toxicology screen was negative for hydrocodone, methadone, and oxycodone, which was inconsistent with his medications. On or about July 23, 2012, Patient F's toxicology screen was negative for methadone and positive for Soma, which was inconsistent with his medications. Despite filling monthly prescriptions for oxycodone with instructions to take four tablets per day, Patient F's toxicology screens were negative for that medication on the following dates: June 14, 2018,[7] August 8, 2019, and October 24, 2019. Despite filling monthly prescriptions for Soma, Patient F's toxicology screens were negative for that medication on the following dates: March 29, 2018; November 28, 2018; May 10, 2019; August 2, 2019; and October 24, 2019. On or about September 5, 2018, Patient F's toxicology screen was negative for methadone, which was

[7] On June 14, 2018, Patient F also tested positive for hydromorphone, which was inconsistent with his medications.

inconsistent with his medications. In addition, Patient F tested positive for ethyl glucuronide on September 5, 2018, and November 28, 2018. Respondent did not document a discussion with Patient F concerning any of these inconsistent test results. Nor did he document a discussion regarding the risk of drinking alcohol while taking opioids.

62. Respondent committed negligence in his care and treatment of Patient F, which included, but is not limited to, the following: failing to document Patient F's mental health status while prescribing opioids on a continuous basis.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

63. Respondent's license is subject to disciplinary action under section 2266, of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, E, and F, as more particularly alleged in paragraphs 22 through 62, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

64. Respondent's license is subject to disciplinary action under Code sections 2227 and 2234, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 21 through 63, above, which are hereby incorporated by reference and realleged 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 No. A 76322, issued to Respondent Athanasios Ssettimba Magimbi, M.D.;

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

3. Ordering Respondent Athanasios Ssettimba Magimbi, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: APR 0 4 2022

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

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