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

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| **In the Matter of the Accusation Against:** | ) | |
| **Mohamed Waddah El-Nachef, M.D.** | ) | **Case No. 800-2016-025032** |
| **Physician's and Surgeon's Certificate No. C50556** | ) | |
| **Respondent** | ) | |

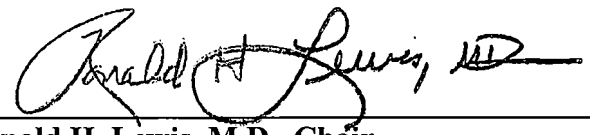
## DECISION

**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 March 6, 2020.**

**IT IS SO ORDERED: February 5, 2020.**

**MEDICAL BOARD OF CALIFORNIA**



**Ronald H. Lewis, M.D., Chair**
**Panel A**

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**MOHAMED W. EL-NACHEF, M.D.**<br>**3010 W Orange Ave., Suite 407**<br>**Anaheim, CA 92804**<br><br>**Physician's and Surgeon's Certificate No. C50556,**<br><br>Respondent. | Case No. 800-2016-025032<br><br>OAH No. 2019080200<br><br>**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. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). This action was brought by then Complainant Kimberly Kirchmeyer solely in her official capacity.[1] Complainant is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Christine A. Rhee, Deputy Attorney General.

[1] Ms. Kirchmeyer became the Director of the Department of Consumer Affairs on October 28, 2019.

2. Respondent Mohamed W. El-Nachef, M.D. (Respondent) is represented in this proceeding by attorney Charles T. Mathews, Esq., whose address is: 45 E. Huntington Drive, Suite 45C, Arcadia, CA 91006.

3. On or about March 29, 2001, the Board issued Physician's and Surgeon's Certificate No. C50556 to Mohamed W. El-Nachef, M.D. (Respondent). Physician's and Surgeon's Certificate No. C50556 was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-025032, and will expire on January 31, 2021, unless renewed.

## JURISDICTION

4. Accusation No. 800-2016-025032 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 May 16, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2016-025032 is attached as Exhibit A and incorporated by reference herein.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-025032. Respondent has also carefully read, fully discussed with 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 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.

8. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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## CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2016-025032.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. C50556 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

11. 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 he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

12. 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

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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**

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. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C50556 issued to Respondent Mohamed W. El-Nachef, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years from the effective date of the Decision, with the following terms and conditions:

1. 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

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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.

2. 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.

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.

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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. 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.

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

component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

6. 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 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. 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 Respondent did not successfully complete the clinical competence assessment program, 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.

7. MONITORING - PRACTICE/BILLING. 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 and billing 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 and billing 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 billing, 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.

8. PROHIBITED PRACTICE. During probation, Respondent is prohibited from practicing in a treatment facility. After the effective date of this Decision, all patients being treated by Respondent shall be notified that Respondent is prohibited from practicing in a treatment facility. 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.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, 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.

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

11. 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.

12. 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.

13. 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(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.

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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.

14. 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.

15. 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

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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; and Quarterly Declarations.

16. 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.

17. 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.

18. 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

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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.

19. 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.

## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Charles T. Mathews, 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: 11. 19. 2019 Mohamed W. El-Nachef, MD

MOHAMED W. EL-NACHEF, M.D.
*Respondent*

I have read and fully discussed with Respondent Mohamed W. El-Nachef, 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: 11/19/2019 Charles T. Mathews

CHARLES T. MATHEWS, ESQ.
*Attorney for Respondent*

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## ENDORSEMENT

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

DATED: 11/21/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
*Attorneys for Complainant*

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Exhibit A:

Accusation No. 800-2016-025032

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*Attorneys for Complainant*



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

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| In the Matter of the Accusation Against:<br><br>**MOHAMED W. EL-NACHEF, M.D.**<br>**3010 W Orange Ave., Suite 407**<br>**Anaheim, CA 92804**<br><br>**Physician's and Surgeon's Certificate No. C50556,**<br><br>Respondent. | Case No. 800-2016-025032<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about March 29, 2001, the Medical Board issued Physician's and Surgeon's Certificate No. C50556 to Mohamed W. El-Nachef, M.D. (Respondent). Physician's and Surgeon's Certificate No. C50556 was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2021, unless renewed.

## JURISDICTION

3. This 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 states, in pertinent part:

"(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, in pertinent part:

"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.

"..."

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

7. Section 2239 of the Code states, in pertinent part:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

"..."

8. 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."

9. Subdivision (c) of Section 4022 of the Code defines "dangerous drug" as "[a]ny drug... that by federal or state law can be lawfully dispensed only on prescription..."

## STATEMENT OF FACTS

10. Respondent, who is board certified in internal medicine and nephrology, worked in private practice in Orange, California from approximately 2001 through 2015. From in or around 2014 through September 2015, Respondent volunteered at God's Property and Sober Living (God's Property), a treatment center, in Los Angeles. Respondent's duties at God's Property were to examine, treat, and prescribe medications to the patients, who had been allegedly recently released from jail or rehab and were HIV[1] positive. Respondent was to monitor these HIV patients and ensure they were taking their medications. Respondent volunteered approximately a half day a week, seeing an average of ten (10) patients in a half day.

Patient A[2]

11. According to God's Property records, Respondent first treated Patient A, then a twenty-three-year-old woman, on or about November 11, 2014. Records for that date include patient intake forms, in which Patient A allegedly wrote that her chief complaint was back pain and HIV. The forms indicate that Patient A had been diagnosed with HIV in 2010.

12. An undated, handwritten progress note signed by Respondent appears to document Respondent's physical examination of Patient A. Under the assessment section of the note, Respondent wrote the following: AIDS, insomnia, depression, and headaches. Under the plan

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[1] HIV is an acronym for the human immunodeficiency virus. AIDS is an acronym for acquired immunodeficiency syndrome, which is the last and most severe stage of HIV infection. The medication used to treat HIV is called antiretroviral therapy (ART). According to the Centers for Disease Control (CDC), AIDS is diagnosed when patients' CD4 cell count drops below 200 cells/mm or if they develop certain opportunistic illnesses.

[2] To protect the privacy of all patients involved, patient names have been omitted from this pleading. Respondent is aware of the identities of the patients referred to herein.

section of the note, Respondent wrote "as per Rx," and listed Seroquel,[3] Abilify,[4] and Fioricet,[5] and that Patient A should return to the clinic in three (3) months. The note failed to specify the dosages and quantities for the prescriptions given at this visit. The note did not document that Respondent ordered any lab tests to verify Patient A's HIV diagnosis at this visit.

13. Records from a pharmacy and the California Department of Health Care Services (DHCS) for Medi-Cal reimbursements show prescriptions written by Respondent for Patient A were filled on or about November 12, 2014 for the following: (1) Abilify; (2) Seroquel XR, 300 mg, quantity 60; (3) Stribild;[6] and (4) Butalbital-Acetaminophen-caffeine. The records indicate that all of these prescriptions were refilled on or about December 29, 2014.

14. According to God's Property records, Patient A saw Respondent for a follow up visit on or about March 12, 2015. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient A. Under the assessment section of the note, Respondent wrote HIV/AIDS, allergies, and a history of depression and insomnia. Under the plan section of the note, Respondent wrote HIV, Latuda,[7] Seroquel, and Benadryl as needed. Respondent failed to document the medical indication for adding Latuda to Patient A's medication regimen.

15. Records from the DHCS show that prescriptions written by Respondent for Patient A were filled on or about March 12, 2015 for the following: (1) Reyataz;[8] (2) Norvir;[9] (3) Seroquel XR, 400 mg, quantity 60; (4) Epzicom;[10] and (5) Latuda. Respondent failed to document the medical indication for switching Patient A's ART medication regimen by adding Reyataz, Norvir,

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[3] Seroquel, brand name for Quetiapine, is an antipsychotic used to treat schizophrenia, bipolar disorder, and depression.

[4] Abilify, brand name for Aripiprazole, is an antipsychotic used to treat schizophrenia, bipolar disorder, and depression.

[5] Fioricet, brand name for Butalbital-Acetaminophen-caffeine, is used to treat tension headaches.

[6] Stribild, brand name for a combination of Elvitegravir (an HIV integrase inhibitor), Cobicistat (a pharmacokinetic enhancer), Emtricitabine (an HIV nucleoside analog reverse transcriptase inhibitor), and Tenofovir (an HIV nucleoside analog reverse transcriptase inhibitor), is used to treat HIV infection.

[7] Latuda, brand name for Lurasidone, is an antipsychotic commonly used to treat schizophrenia.

[8] Reyataz, brand name for Atazanavir, is an HIV protease inhibitor used to treat HIV infection.

[9] Norvir, brand name for Ritonavir, is an HIV protease inhibitor used to treat HIV infection.

[10] Epzicom, brand name for a combination of Abacavir (an HIV nucleoside analog reverse transcriptase inhibitor) and Lamivudine (an HIV nucleoside analog reverse transcriptase inhibitor), is used to treat HIV infection. Abacavir is always used in combination with other ART medications.

and Epzicom, and the reason for increasing her Seroquel dose in the progress note for this visit. The prescriptions for Reyataz, Norvir, Epzicom, and Latuda appear to be refilled on or about April 30, 2015.

16. God's Property records allegedly document that Patient A gave a blood sample to measure her CD4 count[11] on or about June 3, 2015. These results were reported back preliminarily on or about June 4, 2015, and a final report was produced on or about June 7, 2015. God's Property records contain no progress note corresponding to June 3, 2015 that would indicate that Patient A came in for an appointment.

17. On or about March 29, 2018, a Board investigator interviewed Patient A. Patient A told the Board investigator that she had never been treated by Respondent, had never been to a sober living home, and had never been diagnosed with HIV or AIDS. The Board subsequently obtained medical records from Patient A's treatment providers from 2013 through 2016. These records show that Patient A tested negative for HIV.

Patient B

18. Respondent first treated Patient B, then a twenty-four-year old woman, on or about October 2, 2014, at the Cancer Treatment Medical Center (CTMC) located in Anaheim, California. Electronic records for that date indicate that this was a new patient visit. The medications either reported or prescribed in the medical record for Patient B were the following: Abilify, Norco,[12] Promethazine with Codeine,[13] Seroquel, and Stribild. Respondent's typed notes appear to indicate that he physically examined Patient B. Under the assessment section of the note, Respondent wrote HIV, severe PMS (pre-menstrual syndrome), insomnia, depression, and neuropathy. Under the plan section of the note, Respondent wrote HAART,[14] Seroquel, Abilify,

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[11] A CD4 cell count measures the number of T-lymphocytes in a patient's blood. A CD4 cell count gives practitioners an indication of the health of a patient's immune system.

[12] Norco, brand name for a combination of Acetaminophen and Hydrocodone, is an opioid used to treat moderate to severe pain. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I)(i).

[13] Promethazine with Codeine is an antihistamine, pain reliever, and cough suppressant. Codeine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(G).

[14] HAART is a commonly used acronym for highly active antiretroviral therapy. According to the National Institute of Health (NIH), it is a customized combination of different classes of medications that a physician may prescribe.

and "as per orders." Respondent failed to order any lab tests to verify Patient B's HIV diagnosis.

19. Records from a pharmacy and DHCS show that prescriptions written by Respondent for Patient B were filled on or about October 2, 2014 for Abilify, Seroquel, Stribild, and Promethazine with Codeine. The prescriptions for Abilify, Seroquel, and Stribild appear to be refilled on or about November 3, 2014.

20. According to God's Property records, Patient B saw Respondent for a follow up visit on or about December 8, 2014. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient B. Under the assessment section of the note, Respondent wrote AIDS, contact dermatitis, insomnia, and depression. Under the plan section of the note, Respondent wrote HAART, Clobetasol,[15] Seroquel, and Abilify. Patient B was to return for a follow up in three (3) months.

21. Records from the DHCS show that prescriptions written by Respondent for Patient B were filled on or about December 10, 2014 for Stribild, Seroquel, and Abilify. These medications appear to be refilled on or about January 8, 2015 and March 2, 2015.

22. Records from the DHCS show that prescriptions written by Respondent for Patient B were filled on or about April 6, 2015 for Stribild and Latuda.

23. According to God's Property records, Patient B saw Respondent for a follow up visit complaining of severe menstrual cramps on or about April 13, 2015. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient B. Under the assessment section of the note, Respondent wrote AIDS, severe PMS, and a history of insomnia and depression. Under the plan section of the note, Respondent wrote HAART, "Hctz,"[16] "Ty3,"[17] and Latuda. Respondent failed to document the medical indication for prescribing Latuda.

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[15] Clobetasol is a corticosteroid used to treat contact dermatitis.

[16] "Hctz" is an abbreviation for Hydrochlorothiazide, which is a medication used to treat high blood pressure and edema.

[17] "Ty3" is an abbreviation for Tylenol 3, or Tylenol with Codeine.

24. Records from the DHCS show that prescriptions written by Respondent for Patient B were filled on or about April 17, 2015 for Seroquel, Hydrochlorothiazide, Latuda, and Acetaminophen with Codeine #3.

25. God's Property records allegedly show that Patient B gave a blood sample to measure her CD4 count on or about May 1, 2015. These results were reported back preliminarily on or about May 2, 2015, and a final report was produced on or about May 5, 2015. God's Property records contain no progress note corresponding to May 1, 2015 indicating Patient B came in for an appointment.

26. Records from the DHCS show that Patient B's prescriptions for Hydrochlorothiazide and Latuda were refilled on or about May 6, 2015. The records also show that Patient B's prescriptions for Stribild and Seroquel were refilled on or about May 21, 2015. More refills for Latuda were filled on or about June 1, 2015 and June 27, 2015, while refills for Stribild were filled six (6) more times on or about the following dates: (1) July 14, 2015; (2) August 9, 2015; (3) September 1, 2015; (4) October 1, 2015; (5) October 31, 2015; and (6) November 25, 2015. The records indicate that all of these prescriptions were written by Respondent.

27. On or about December 15, 2017, a Board investigator interviewed Patient B. Patient B told the Board investigator that she had never been treated by Respondent and has never been diagnosed with HIV or AIDS. The Board obtained medical records from Patient B's treatment providers from 2016 showing no indication that Patient B had HIV or AIDS.

Patient C

28. According to God's Property records, Respondent first treated Patient C, then a forty-year old man, on or about June 23, 2014, at the CTMC. Typed records for that date indicate that this was a new patient visit. The medications either reported or prescribed in the medical record for Patient C were Abilify, Neurontin,[18] Norvir, Oxycodone,[19] Prezista,[20] Seroquel, and

[18] Neurontin, brand name for Gabapentin, is a nerve pain medication used to treat chronic pain and neuropathy.

[19] Oxycodone, brand name Oxycontin, is an opioid used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M).

[20] Prezista, brand name for Darunavir, is an HIV protease inhibitor used to treat HIV infection.

Truvada.[21] Respondent's typed notes appear to indicate that he physically examined Patient C. Respondent documented that Patient C reported pain in his hands and feet, which was severe at times, and noted that Patient C had foul smelling toes, a history of HIV, and insomnia. Under the assessment section of the note, Respondent wrote HIV, yeast web maceration, insomnia, peripheral polyneuropathy. Under the plan section of the note, Respondent wrote "as per Rx" twice, "keep feet off moisture," and Neurontin. Respondent noted that labs were ordered in his note but failed to document what specific lab testing was ordered.

29. Records from a pharmacy and the DHCS show that prescriptions written by Respondent for Patient C were filled on or about June 23, 2014 for Norvir, Seroquel, Abilify, Prezista, and Truvada.

30. A review of Respondent's Controlled Substance Utilization Review & Evaluation System (CURES)[22] prescribing history shows that Respondent wrote a prescription for Patient C which was filled on or about June 28, 2014 for Oxycodone, 30 mg, quantity 120. Respondent however, failed to document in his progress note why Oxycodone was medically indicated, especially at such a high daily amount of 270 morphine equivalent doses[23] (MED).

31. According to God's Property records, Patient C again saw Respondent at the CTMC on or about July 23, 2014, for a follow up and to refill his medications. Under the assessment section of the note, Respondent wrote HIV, that Patient C's yeast infection was better, insomnia, and peripheral polyneuropathy. He also wrote that labs were ordered but did not specify what type of lab testing. Under the plan section of the note, Respondent wrote "as per Rx" twice, "keep feet off moisture," Neurontin, and "check B12 and folate."

32. Records from a pharmacy and the DHCS records show that prescriptions written by Respondent for Patient C were filled on or about July 23, 2014 for Gabapentin, Norvir, Seroquel, Abilify, Prezista, and Truvada.

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[21] Truvada, brand name for a combination of Emtricitabine and Tenofovir, is used to treat HIV infection.

[22] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

[23] Morphine equivalent doses (MED) are used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED. MED calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations.

33. Records from a pharmacy, the DHCS, and CURES also show that a prescription for Oxycodone, 30 mg, quantity 120, which was written by Respondent for Patient C, was filled on or about July 24, 2014. Respondent's July 23, 2014 note documents that Oxycodone, 30 mg, two tablets three times a day was added at that visit. Respondent however, failed to document in his note why Oxycodone was medically indicated, especially at such a high daily dose.

34. God's Property records show that Patient C gave a blood sample for a complete blood count and metabolic panel on or about August 16, 2014. These results were reported back on or about August 18, 2014. God's Property records contain no progress note corresponding to August 16, 2014, indicating Patient C came in for an appointment. There was no documented testing related to Patient C's HIV status.

35. Records from the DHCS show that Patient C's prescriptions for Norvir, Seroquel, Abilify, Prezista, and Truvada, written by Respondent, were refilled on or about August 21, 2014.

36. Records from the DHCS show that Patient C's prescriptions for Norvir, Seroquel, Abilify, Prezista, and Truvada, written by Respondent, were refilled on or about September 23, 2014.

37. According to God's Property records, Patient C saw another physician and surgeon, K.A., at the CTMC on or about October 29, 2014 for a follow up. Records from the DHCS, however, show Patient C's prescriptions for Norvir, Seroquel, Abilify, Prezista, and Truvada, filled on or about October 29, 2014, were ordered by another treatment provider, A.D.H.

38. On or about December 8, 2014, Patient C saw Respondent for a follow up at God's Property in Los Angeles. God's Property records for that date include patient intake forms that indicate that Patient C was diagnosed with HIV in 1999. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient C. Under the assessment section of the note, Respondent wrote AIDS, hypertension, a tonsil mass, and insomnia. Under the plan section of the note, Respondent wrote HAART, Norvasc,[24] and Seroquel, and that Patient

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[24] Norvasc, brand name for Amlodipine, is a calcium channel blocker used to treat high blood pressure and chest pain.

C should return for a follow up in three (3) months. God's Property records include copies of Respondent's prescriptions for Patient C on this date for Seroquel, Abilify, and Prezista.

39. Records from the DHCS show that prescriptions written by Respondent for Patient C were filled on or about December 10, 2014 for Amlodipine, Prezista, Truvada, Seroquel, and Abilify.

40. Records from the DHCS show that prescriptions for Patient C written by Respondent were filled on or about December 11, 2014 for the following: (1) Tramadol,[25] 300 mg, quantity 10; and (2) Meloxicam.[26] Records from the DHCS also show that a prescription for Gabapentin for Patient C written by Respondent was filled on or about February 26, 2015. Records of these prescriptions or any associated progress notes are not in Patient C's God's Property records.

41. God's Property records show that Patient C gave a blood sample for a CD4 count on or about March 25, 2015. These results were reported back on or about March 26-27, 2015. God's Property records contain no progress note corresponding to March 25, 2015, indicating Patient C came in for an appointment.

42. On or about April 13, 2015, Patient C saw Respondent for a follow up at God's Property in Los Angeles. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient C. Under the assessment section of the note, Respondent wrote HIV, history of depression, history of insomnia, and hypertension. Under the plan section of the note, Respondent wrote HAART, Latuda, Seroquel, and Hyzaar.[27] God's Property records include copies of Respondent's prescriptions for Patient C on this date for Losartan, Seroquel, Latuda, Prezista, and Truvada.

43. Records from the DHCS show that prescriptions for Patient C written by Respondent were filled on or about April 13, 2015, for Losartan, Prezista, Truvada, and Latuda. These four prescriptions appear to be refilled on or about the following dates: (1) May 8, 2015; (2) June 1, 2015; and (3) June 27, 2015.

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[25] Tramadol, brand name Ultram, is a narcotic-like pain reliever and a dangerous drug pursuant to Business and Professions Code section 4022.

[26] Meloxicam, brand name Mobic, is a nonsteroidal anti-inflammatory drug (NSAID) used to treat arthritis.

[27] Hyzaar, brand name for Hydrchlorothiazide and Losartan, is a drug used to treat high blood pressure.

44. God's Property records show that Patient C gave another blood sample for a CD4 count on or about April 16, 2015. These results were reported back on or about April 17, 2015. God's Property records contain no progress note corresponding to April 17, 2015, indicating Patient C came in for an appointment. Respondent failed to document why another CD4 count was medically indicated after Patient C had gotten a CD4 count less than a month prior. The results showed HIV viremia at approximately 61,000 copies. God's Property records contain no documentation showing how HIV viremia was addressed.

45. On or about August 3, 2015, Patient C saw Respondent for a follow up at God's Property in Los Angeles. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient C. Respondent noted that Patient C smelled of alcohol, and Patient C reported that he had been binge drinking. Under the assessment section of the handwritten note, Respondent wrote HIV, history of depression, and binge drinking. Under the plan section of the note, Respondent wrote HAART, Latuda, "join AA," and Librium[28] as needed. God's Property records include copies of Respondent's prescriptions for Patient C on this date for Latuda, Stribild, and Librium. Records from the DHCS indicate that these prescriptions were filled on or about August 3, 2015. Respondent failed to document why he switched Patient C's ART regimen from Prezista and Truvada to Stribild.

46. Records from the DHCS show that prescriptions for Patient C written by Respondent for Stribild continued to be written and filled on or about August 31, 2015, September 30, 2015, and October 24, 2015. Records from the DHCS show that prescriptions for Patient C written by Respondent for Latuda continued to be written and filled on or about September 30, 2015 and October 24, 2015.

47. Board investigators obtained records from the Los Angeles County Sheriff's Department for Patient C, who had been incarcerated in or around April 2014. In those medical records, including a medical screening form signed by Patient C, he did not indicate that he had HIV or AIDS, in direct contradiction to the intake forms from God's Property.

[28] Librium, brand name for Chlordiazepoxide, is a benzodiazepine used to treat alcohol withdrawal. Librium is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(5).

Patient D

48. According to God's Property records, Respondent first treated Patient D, then a fifty-seven-year old man, on or about September 4, 2014, at the CTMC. Typed records for that date indicate that this was a new patient visit. The medications either reported or prescribed in the medical record for Patient D were the following: Abilify, Seroquel, Norco, and Stribild. According to Respondent's typed notes, Patient D complained of chronic pains, tingling in feet and hands, erectile dysfunction, and insomnia. Respondent's notes indicate that he physically examined Patient D. Under the assessment section of the note, Respondent wrote HIV, insomnia, neuropathy, erectile dysfunction, hypogonadism, and depression. Under the plan section of the note, Respondent wrote "as per Rx," Seroquel, Gabapentin, Viagra, check male hormones, and Abilify. Respondent failed to order lab tests at this initial visit to verify Patient D's HIV diagnosis.

49. Records for a pharmacy and the DHCS show that prescriptions for Patient D written by Respondent were filled on or about September 4, 2014 for the following: (1) Stribild; and (2) Hydrocodone, 10-325 mg, quantity 90. Respondent failed to document in the progress note why Hydrocodone was medically indicated.

50. Records for a pharmacy show that prescriptions for Patient D written by Respondent were filled on or about October 3, 2014 for Stribild, Seroquel, and Abilify. Records from the DHCS show that the only prescription filled on or about October 3, 2014 for Patient D was Stribild.

51. On or about October 14, 2014, Patient D saw Respondent again at the CTMC for a follow up. According to Respondent's notes, Patient D continued to complain of tingling in his feet and hands, erectile dysfunction, insomnia, and anxiety. The note also documents that Patient D had not filled a prescription for testosterone,[29] even though no mention of testosterone can be found in the prior note. Respondent documented another physical examination. Under the assessment section of the note, Respondent wrote HIV, insomnia, neuropathy, erectile

[29] Testosterone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f)(30).

dysfunction, hypogonadism, and depression. Under the plan section of the note, Respondent wrote "as per Rx," Seroquel, Gabapentin, Viagra, depo testosterone, Xanax,[30] and Abilify.

52. Records from a pharmacy, the DHCS, and CURES show that a prescription written by Respondent for Patient D was filled on or about October 14, 2014 for Alprazolam, 2 mg, quantity 30. These records also show that a prescription written by Respondent for Patient D was filled on or about October 17, 2014 for Oxycodone, 30 mg, quantity 60. Respondent failed to document the medical indication for prescribing Oxycodone to Patient D in his progress note.

53. Records from a pharmacy show that prescriptions written by Respondent for Patient D were filled on or about November 6, 2014 for Stribild, Abilify, and Seroquel. Records from the DHCS show that the Abilify and Stribild prescriptions were filled on the same date.

54. On or about December 8, 2014, Patient D saw Respondent for a follow up at God's Property in Los Angeles. Even though he was not a new patient, Patient D filled out and signed intake forms, saying his chief complaint was HIV. The handwritten progress note for this visit appears to document Respondent's physical examination of Patient D. Respondent noted that Patient D reported poor sleep and that he had fallen and broken his wrist with surgery planned. Respondent noted that Patient D had a splint on his left wrist. Under the assessment section of the handwritten note, Respondent wrote AIDS, fracture of left wrist, insomnia, and depression. Under the plan section of the note, Respondent wrote HAART, "surgery is planned," Trazodone,[31] and Abilify. Respondent noted that Patient D should return for a follow up in three (3) months.

55. God's Property records show that Patient D gave a blood sample for a CD4 count on or about March 5, 2015. These results were reported back on or about March 6, 2015. God's Property records contain no progress note corresponding to March 5, 2015, indicating Patient D came in for an appointment. The results showed HIV viremia at approximately 29,000 copies. God's Property records contain no documentation showing how HIV viremia was addressed.

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[30] Xanax, brand name for Alprazolam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1).

[31] Trazodone, brand name Oleptro, is a sedative and antidepressant.

56. On or about March 9, 2015, Patient D saw Respondent for a follow up at God's Property in Los Angeles. Patient D reported fair pain control, and Respondent documented another physical exam. Under the assessment section of the handwritten note, Respondent wrote HIV/AIDS, chronic pains, and depression. Under the plan section of the note, he wrote HAART, Motrin/Oxycodone, and Latuda. God's Property records include a copy of Respondent's prescription for Oxycodone, 30 mg, quantity 60. The records also include a copy of the following new prescriptions given to Patient D at this visit: Tivicay,[32] Truvada, Norvir, and Latuda. Respondent failed to document the medical indication for prescribing Latuda, and the reasons for switching Patient D's HIV drug regimen from Stribild to Tivicay and Truvada. Respondent also made no indication in the medical records that he reviewed the lab results with Patient D.

57. Records from the DHCS show prescriptions for Patient D written by Respondent were filled on or about March 20, 2015, for the following: (1) Norvir; (2) Tivicay; (3) Truvada; (4) Latuda; and (5) Oxycodone, 30 mg, quantity 60. Patient D's prescriptions for Norvir, Tivicay, Truvada, and Latuda continued to be refilled on or about the following dates: (1) April 12, 2015; (2) May 8, 2015; (3) May 11, 2015; (4) June 4, 2015; (5) October 31, 2015; (6) November 25, 2015; and (7) December 23, 2015.

58. Board investigators obtained records from the Los Angeles County Sheriff's Department for Patient D, who had been incarcerated in or around April 2016. In those medical records, Patient D denied having any communicable disease in direct contradiction to his intake forms from God's Property.

Patient E

59. According to God's Property records, Respondent first treated Patient E, then a fifty-one-year old man, on or about June 26, 2014, at the CTMC. Typed records for that date indicate that this was a new patient visit. The medications either reported or prescribed in the medical record for Patient E were Abilify, Isentress,[33] Neurontin, Prezista, Seroquel, and Truvada. According to Respondent's typed notes, Patient E complained of tingling in his feet, insomnia,

[32] Tivicay, brand name for Dolutegravir, is an integrase inhibitor used in combination with other antiretroviral medications to treat HIV infection.

[33] Isentress, brand name for Raltegravir, is an integrase inhibitor used to treat HIV infection.

and chronic aches. Respondent's notes indicate that he physically examined Patient E. Under the assessment section of the note, Respondent wrote neuropathy, HIV, "psychology," and chronic pain. Under the plan section of the note, Respondent wrote Neurontin, 300 mg QHS and "as per Rx" three times. Respondent failed to order lab tests at this initial visit to verify Patient E's HIV diagnosis.

60. Records from a pharmacy or the DHCS show that prescriptions for Patient E written by Respondent were filled on or about June 26, 2014 for the following: (1) Seroquel; (2) Abilify; (3) Truvada; (4) Prezista; (5) Isentress; and (6) Gabapentin, 300 mg, quantity 30.

61. On or about July 23, 2014, Patient E saw Respondent for a follow up at the CTMC. Respondent documented that Patient E's tingling feet were better but that he still had insomnia and chronic aches. Respondent's typed notes indicate that he physically examined Patient E and that Patient E's back's range of motion was mildly decreased by spasms. Under the assessment section of the note, Respondent wrote neuropathy, HIV, "psychology," and "chronic pain back with muscle tightness." Under the plan section of the note, Respondent prescribed Neurontin and Xanax "to promote better sleep" and wrote "as per Rx" three times.

62. Records from a pharmacy and the DHCS show that prescriptions written by Respondent for Patient E were filled on or about July 24, 2014 for the following: (1) Seroquel; (2) Abilify; (3) Truvada; (4) Prezista; (5) Isentress; (6) Gabapentin; (7) Oxycodone, 30 mg, quantity 60; and (8) Alprazolam, 0.5 mg, quantity 30. The prescriptions for Gabapentin, Isentress, Seroquel, Abilify, Prezista, and Truvada appear to be refilled on or about August 22, 2014.

63. God's Property records show that Patient E gave a blood sample for a complete blood count on or about August 2, 2014. These results were reported back on or about August 4, 2014. God's Property records contain no progress note corresponding to August 2, 2014, indicating Patient E came in for an appointment. These labs did not include tests that would confirm Patient E's HIV status.

64. On or about November 12, 2014, Patient E saw Respondent at God's Property in Los Angeles. Even though he was not a new patient, Patient E filled out and signed intake forms, saying his chief complaint was pain, depression, and HIV. Patient E reported back, feet, and hand

pain, erratic sleep, weight loss, and decreased energy. Respondent documented a physical exam. Under the assessment section of the handwritten note, Respondent wrote AIDS, neuropathy, insomnia, and depression. Under the plan section of the note, he wrote HAART, "Neurontin, 600 mg," Xanax, Seroquel, and Abilify, and that Patient E should return in three (3) months. Respondent failed to document the medical indication for doubling Patient E's Gabapentin dose and adding Xanax.

65. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about December 11, 2014 for the following: (1) Gabapentin, 600 mg, quantity 60; (2) Oxycodone, 30 mg, quantity 60; (3) Alprazolam, 2 mg, quantity 30; (4) Seroquel; (5) Abilify; and (6) Stribild. Respondent failed to document the medical indication for the increased dose for Alprazolam and for changing Patient E's HIV drug regimen from Isentress, Prezista, and Truvada to Stribild.

66. Records from the DHCS show that Patient E's prescriptions for Gabapentin, Alprazolam, Abilify, Stribild, and Seroquel were refilled on or about January 5, 2015 and January 6, 2015.

67. Records from the DHCS and CURES show that a prescription written by Respondent for Patient E was filled on or about January 9, 2015 for Oxycodone, 30 mg, quantity 60. God's Property records fail to document this prescription or any office visits associated with this prescription.

68. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about January 29, 2015 for the following: (1) Gabapentin, 600 mg, quantity 60; (2) Alprazolam, 2 mg, quantity 30; (3) Seroquel; (4) Abilify; and Stribild. God's Property records fail to document this prescription or any office visits associated with this prescription.

69. God's Property records show that Patient E gave blood sample for a CD4 count on or about February 3, 2015. These results were reported back on or about March 3, 2015. God's Property records contain no progress note corresponding to February 3, 2015, indicating Patient E came in for an appointment.

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70. On or about February 9, 2015, it appears that Patient E came to God's Property and had his vital signs taken. Records from God's Property include a copy of a prescription Respondent gave to Patient E on that day for Oxycodone, 30 mg, quantity 60.

71. On or about February 11, 2015, Patient E saw Respondent at God's Property in Los Angeles for a follow up. Patient E reported pain in his feet and toes, anxiety, and depression. Respondent's handwritten notes document a physical exam. Under the assessment section of the note, Respondent wrote AIDS, neuropathy, and insomnia. Under the plan section of the note, Respondent wrote HAART, Tramadol, and Seroquel. Respondent failed to document the medical indication for adding Tramadol to Patient E's drug regimen.

72. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about February 12, 2015 for the following: (1) the Oxycodone prescription dated February 9, 2015; (2) Naproxen;[34] and (3) Tramadol, 50 mg, quantity 100.

73. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about February 23, 2015 for the following: (1) Gabapentin, 600 mg, quantity 60; (2) Alprazolam, 2 mg, quantity 30; (3) Abilify; and (4) Stribild. The prescriptions for Gabapentin, Abilify, and Stribild were refilled on or about March 18, 2015. God's Property records fail to document these prescriptions or any office visits associated with these prescriptions.

74. Records from the DHCS and CURES show that a prescription written by Respondent for Patient E for Oxycodone, 30 mg, quantity 60, was filled on or about March 19, 2015. God's Property records fail to document this prescription or any office visits associated with this prescription.

75. Records from the DHCS and CURES show that two prescriptions written by Respondent for Patient E for Alprazolam, 2 mg, quantity 30, were filled on or about March 23, 2015 and April 15, 2015. God's Property records do not document these prescriptions or any associated visit.

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[34] Naproxen, brand name Aleve, is a NSAID over-the-counter medication.

76. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about April 15, 2015 for Seroquel, Abilify, and Stribild.

77. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about May 12, 2015 for the following: (1) Gabapentin, 600 mg, quantity 60; (2) Naproxen; (3) Alprazolam, 2 mg, quantity 30; (4) Seroquel; (5) Abilify; and (6) Stribild. God's Property records show that Patient E's vital signs were taken on or about May 11, 2015, but there is no progress note for that day, indicating that Patient E was seen by Respondent or prescribed these medications.

78. Records from the DHCS and CURES show that a prescription for Oxycodone, 30 mg, quantity 30, written by Respondent for Patient E was filled on or about May 13, 2015. God's Property records do not document this prescription or any associated visit.

79. Records from the DHCS show that the Gabapentin, Naproxen, Alprazolam, Abilify, and Stribild prescriptions written by Respondent for Patient E were refilled on or about June 8, 2015. God's Property records do not document these prescriptions or any associated visit.

80. Records from the DHCS and CURES show that a prescription for Oxycodone, 30 mg, quantity 45, written by Respondent for Patient E was filled on or about June 30, 2015. God's Property records do not document this prescription, the justification for the increase in dosage, or any associated visit.

81. Records from the DHCS show that the Gabapentin, Naproxen, Abilify, and Stribild prescriptions written by Respondent for Patient E were filled on or about July 6, 2015. God's Property records do not document these prescriptions or any associated visit.

82. Records from the DHCS show that a prescription for Alprazolam, 2 mg, quantity 30, written by Respondent for Patient E was filled on or about July 13, 2015. God's Property records do not document this prescription or any associated visit.

83. Records from the DHCS show that a prescription for Oxycodone, 30 mg, quantity 45, written by Respondent for Patient E was filled on or about July 21, 2015. God's Property records do not document this prescription or any associated visit.

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84. Records from the DHCS show that the Gabapentin, Naproxen, Abilify, and Stribild prescriptions written by Respondent for Patient E were filled on or about August 3, 2015. God's Property records do not document these prescriptions or any associated visit.

85. Records from the DHCS and CURES show that a prescription for Oxycodone, 30 mg, quantity 45, written by Respondent for Patient E was filled on or about August 28, 2015. God's Property records do not document this prescription or any associated visit.

86. Records from the DHCS show that the Gabapentin and Naproxen prescriptions written by Respondent for Patient E were filled on or about September 28, 2015. God's Property records show that Patient E's vital signs were taken on or about September 28, 2015, but there is no progress note for that day, indicating that Patient E was seen by Respondent or prescribed these medications.

87. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about September 29, 2015 for the following: (1) Oxycodone, 30 mg, quantity 45; (2) Alprazolam, 2 mg, quantity 30; (3) Triumeq;[35] and (4) Latuda. God's Property records do not document these prescriptions, any associated visit, or the medical indication for prescribing Latuda and the justification for switching Patient E from Stribild to Triumeq.

88. Records from the DHCS show that prescriptions written by Respondent for Patient E were filled on or about November 2, 2015 for the following: (1) Naproxen; (2) Gabapentin, 600 mg, quantity 60; (3) Alprazolam, 2 mg, quantity 30; (4) Triumeq; and (5) Latuda. God's Property records do not document these prescriptions or any associated visit.

89. Board investigators obtained records from the Los Angeles County Sheriff's Department for Patient E, who had been incarcerated in or around February and March 2014. In those medical records, Patient E denied having any communicable disease in direct contradiction to his intake forms with God's Property.

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[35] Triumeq, brand name for a combination of Abacavir, Dolutegravir, and Lamivudine, is used to treat HIV infection.

Patient F

90. According to God's Property records, Respondent first treated Patient F, then a forty-two-year old man, on or about September 2, 2014, at the CTMC in Anaheim. Typed records for that date indicate that this was a new patient visit. In his intake forms, Patient F listed HIV, depression, and sleep issues as his current medical problems. The medications either reported or prescribed in the medical record for Patient F were Abilify, Epzicom, Gabapentin, Norvir, Percocet,[36] Prezista, Promethazine with Codeine, Seroquel, and Truvada. Patient F complained of right leg pain, cough, and pain tingling in his hands and feet. Respondent's typed notes indicate that he physically examined Patient F. Under the assessment section of the note, Respondent wrote HIV, acute bronchitis, smoker, neuropathy, and insomnia. Under the plan section of the note, Respondent wrote "as per Rx," Ceftin,[37] Promethazine, counseling, Gabapentin and Seroquel. Respondent failed to order any lab tests to verify Patient F's HIV diagnosis.

91. Records from a pharmacy and the DHCS show that prescriptions written by Respondent for Patient F were filled on or about September 2, 2014 for Seroquel, Abilify, Prezista, Epzicom, Truvada, (6) Norvir, Promethazine with Codeine, and Gabapentin.

92. Records from a pharmacy and the DHCS show that the Seroquel, Abilify, Prezista, Truvada, Epzicom, and Norvir prescriptions written by Respondent for Patient F were refilled on or about September 29, 2014 and October 29, 2014.

93. On or about December 8, 2014, Patient F saw Respondent at God's Property in Los Angeles for a follow up. Even though he was not a new patient, Patient F filled out and signed another set of intake forms, saying his chief complaint was HIV. The handwritten records document that Patient F also complained of pain in his right leg and a cough. Respondent documented a physical exam. He noted that Patient F had hardware in his leg and had a cough. Under the assessment section of the note, Respondent wrote AIDS, muscular pains, upper respiratory infection, and insomnia. Under the plan section of the note, he wrote HAART,

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[36] Percocet is the brand name for a combination of Acetaminophen and Oxycodone.
[37] Ceftin, brand name for Cefuroxime, is an antibiotic.

NSAIDs, Doxycycline,[38] Promethazine, and Seroquel, and that Patient F should return in three (3) months.

94. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled on or about December 10, 2014 for Tylenol with Codeine #4, Doxycycline, Promethazine with Codeine, Norvir, Epzicom, Prezista, Truvada, and Seroquel. The prescriptions for Norvir, Epzicom, Prezista, Truvada, Seroquel, and Promethazine with Codeine were refilled on or about January 5, 2015 and January 7, 2015.

95. God's Property records show that Patient F gave a blood sample for a CD4 count on or about February 9, 2015. These results were reported back on or about February 11, 2015. God's Property records contain no progress note corresponding to February 9, 2015, indicating Patient F came in for an appointment.

96. On or about February 12, 2015, Patient F saw Respondent at God's Property in Los Angeles for a follow up visit. Respondent's notes document that Patient F had pain in his right ankle, and a cough. Respondent also noted that the hardware in Patient F's leg stuck out under his skin. Under the assessment section of the note, Respondent wrote AIDS, malformed right ankle, and acute bronchitis. Under the plan section of the note, Respondent wrote HAART, referral to an orthopedist, and Augmentin.[39]

97. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled on or about February 16, 2015 for the following: (1) Promethazine with Codeine; (2) Amoxicillin; (3) Tramadol, 50 mg, quantity 100; (4) Norvir; (5) Epzicom; (6) Prezista; (7) Truvada; (8) Seroquel; and (9) Abilify. Respondent failed to document the medical indication for prescribing Tramadol to Patient F.

98. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled on or about March 12, 2015 for Norvir, Epzicom, Prezista, Truvada, Latuda, and Seroquel. Respondent failed to document the medical indication for prescribing Latuda to Patient F.

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[38] Doxycycline is an antibiotic.

[39] Augmentin, brand name for Amoxicillin, is an antibiotic.

99. Records from the DHCS show that Patient F's Norvir, Epzicom, Prezista, Truvada, Latuda, and Seroquel prescriptions were filled on or about April 6, 2015, May 15, 2015, and May 18, 2015.

100. On or about June 30, 2015, Patient F saw Respondent at God's Property in Los Angeles for a follow up. In the handwritten note, Respondent documented that Patient F said he had better sleep. Under the assessment section of the note, Respondent wrote HIV, history of depression, and history of insomnia. Under the plan section of the note, Respondent wrote HAART, Latuda, and Xanax. Respondent failed to document the medical indication for adding Xanax to Patient F's drug regimen.

101. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled on or about June 30, 2015 for the following: (1) Alprazolam, 2 mg, quantity 30; (2) Atripla;[40] and (3) Latuda. Respondent failed to document the reasons why he switched Patient F's ART regimen from Norvir, Epzicom, Prezista, and Truvada to Atripla.

102. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled in or around July through October 2015 for Atripla and Latuda. There are no corresponding medical records documenting these prescriptions.

103. On or about October 20, 2015, Patient F saw Respondent at God's Property in Los Angeles for a follow up. In the handwritten note, Respondent documented that Patient F had switched from cigarettes to e-cigarettes, and has a dry cough. Under the assessment section of the note, Respondent wrote HIV, smoker's cough, and history of depression and insomnia. Under the plan section of the note, Respondent wrote HAART, Latuda, and Xanax. Respondent failed to document why he switched Patient F's ART regimen to Atripla.

104. Records from the DHCS show that prescriptions written by Respondent for Patient F were filled in or around November through December 2015 for Atripla and Latuda. There are no corresponding medical records documenting these prescriptions.

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[40] Atripla, brand name for a combination of Efavirenz (a non-nucleoside reverse transcriptase inhibitor), Emtricitabine, and Tenovofir, is an HIV nucleoside analog reverse transcriptase inhibitor and antiviral used to treat HIV.

105. Board investigators obtained records from the Los Angeles County Sheriff's Department for Patient F, who had been incarcerated in or around February 2009. In those medical records, Patient F denied having any communicable disease.

106. On or about March 14, 2018 and April 4, 2018, Board investigators interviewed Respondent about his care and treatment of Patients A, B, C, D, E, and F. Respondent told Board investigators the following:

a. When asked about how he wrote HIV and AIDS interchangeably in the medical records, Respondent said that clinically, calling it HIV or AIDS did not matter, and that he did not pay much attention to the differentiation.

b. Respondent generally explained that his role was to temporarily treat these patients until they transferred their care to a permanent physician. As such, he would refill their medications based upon either the medications the patients reported taking or by the prescription bottles that the patients brought in. Respondent acknowledged that he never reviewed prior medical records for Patients A, B, C, D, E, or F, and that he failed to order lab testing at each patient's initial visit.

c. Respondent explained that he saw some of the God's Property patients temporarily at the CTMC in Anaheim during a period in which God's Property's clinic in Los Angeles was being renovated or was not ready to use.

d. Respondent also explained that copies of all his prescriptions were normally kept in the patient's chart, and that was the way he documented what prescriptions and refills were given to each patient.

e. Respondent's custom and practice for these patients was to order lab testing every six months to a year. When asked why, in some cases, he did not order lab testing for patients at their initial visit, Respondent said that the patients were transient and he did not expect to see them more than a few times. He said that if patients would only stay at God's Property for less than six months, then there was no need to order lab testing.

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f. When asked why he switched some of the patient's ART medications, Respondent said that in the early part of 2015, the CDC changed the management of HIV and that first line medications were replaced. Respondent acknowledged that there was nothing in his progress notes that would document his rationale for changing the ART medications.

107. On or about May 14 and 22, 2018, Board investigators retrieved prescriptions showing Respondent self-prescribed the following controlled substances:

a. Testosterone on or about April 12, 2014;

b. Testosterone on or about May 27, 2014; and

c. Testosterone on or about May 18, 2015.

**FIRST CAUSE FOR DISCIPLINE**
**(Gross Negligence)**

108. Respondent has subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in the care and treatment of Patients A, B, C, D, E, and F, for the following:

109. Paragraphs 10 through 106, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

110. Respondent committed gross negligence in the care and treatment of Patient A for the following:

a. Failing to document standard components of an initial history and physical including medical history, treatment history, family history, social history, and medication allergies;

b. Failing to order, review, or document confirmation and evidence of Patient A's HIV status within the first three (3) to six (6) months of treatment;

c. Failing to order, review, or document a panel of initial labs including HIV serology, CD4 count, HIV viral load, resistance testing, Hepatitis B and C serology, a

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basic chemistry panel, lipid profile, fasting glucose or hemoglobin A1c, and urinalysis in Patient A's initial visits;

d. Failing to routinely monitor and document Patient A's renal function and chemistries while being prescribed Tenofovir;[41]

e. Failing to properly follow up on Patient A's treatment by documenting work up or evaluation of HIV viremia, documenting Patient A's medication compliance, and ordering and reviewing follow up lab tests to monitor potential virus suppression or mutation; and

f. Failing to check Patient A's HLA-B*5701 status prior to prescribing Abacavir.

111. Respondent committed gross negligence in the care and treatment of Patient B for the following:

a. Failing to order, review, or document confirmation and evidence of Patient B's HIV status within the first three (3) to six (6) months of treatment;

b. Failing to order, review, or document a panel of initial labs including HIV serology, CD4 count, HIV viral load, resistance testing, Hepatitis B and C serology, a basic chemistry panel, lipid profile, fasting glucose or hemoglobin A1c, and urinalysis in Patient B's initial visits;

c. Failing to continue to monitor HIV viral load, basic chemistries, complete blood count, and CD4 count every three (3) to four (4) months to document viral suppression; and

d. Failing to routinely monitor and document Patient B's renal function and chemistries while being prescribed Tenofovir.

112. Respondent committed gross negligence in the care and treatment of Patient C for the following:

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[41] A small proportion of patients experience Tenofovir-associated nephrotoxicity, requiring routine monitoring of renal function and chemistries every three (3) to six (6) months.

a. Failing to order, review, or document a panel of initial labs including HIV serology, CD4 count, HIV viral load, resistance testing, Hepatitis B and C serology, a basic chemistry panel, lipid profile, fasting glucose or hemoglobin A1c, and urinalysis in Patient C's initial visits;

b. Failing to properly follow up on Patient C's treatment by documenting work up or evaluation of HIV viremia, documenting Patient C's medication compliance, and ordering and reviewing follow up lab tests to monitor potential virus suppression or mutation; and

c. Improperly prescribing Oxycodone to Patient C to treat alcoholic polyneuropathy.

113. Respondent committed gross negligence in the care and treatment of Patient D for the following:

a. Failing to order, review, or document confirmation and evidence of Patient D's HIV status within the first three (3) to six (6) months of treatment;

b. Failing to order, review, or document a CD4 count, HIV viral load, resistance testing, Hepatitis B and C serology, basic chemistry panel, lipid profile, fasting glucose or hemoglobin A1c, and urinalysis at Patient D's initial visit;

c. Failing to properly follow up on Patient D's treatment by documenting work up or evaluation of HIV viremia, documenting Patient D's medication compliance, and ordering and reviewing follow up lab tests to monitor potential virus suppression or mutation; and

d. Prescribing an inappropriate ART regimen by prescribing Norvir without a protease inhibitor.[42]

114. Respondent committed gross negligence in the care and treatment of Patient E for the following:

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[42] Norvir has no intrinsic antiretroviral activity, and is used as a boosting agent for protease inhibitors in order to increase protease inhibitor efficacy.

a. Failing to order, review or document confirmation and evidence of Patient E's HIV status by checking Patient E's HIV viral load;

b. Failing to order, review, or document a CD4 count, HIV viral load, resistance testing, Hepatitis B and C serology, basic chemistry panel, lipid profile, fasting glucose or hemoglobin A1c, and urinalysis at Patient E's initial visit;

c. Prescribing an inappropriate ART regimen by prescribing Patient E a protease inhibitor (Darunavir) without boosting with Ritonavir;[43] and

d. Failing to check Patient E's HLA-B*5701 status before switching Patient E's ART regimen to include Abacavir (found in Triumeq).[44]

115. Respondent committed gross negligence in the care and treatment of Patient F for the following:

a. Failing to order, review or document confirmation and evidence of Patient F's HIV status within the first three to six months of treatment;

b. Failing to order a CD4 count at the initial visit;

c. Failing to order and review a basic chemistry panel, including the evaluation of kidney function and liver function, a lipid panel, and hemoglobin A1c for Patient F at the initial or any subsequent visit;

d. Failing to document the justification for and simultaneously prescribing Prezista, Epzicom, Truvada, and Norvir, four (4) nucleoside reverse transcriptase inhibitors, without also prescribing a protease inhibitor;[45] and

e. Failing to properly follow up on Patient F's treatment by documenting work up or evaluation of HIV viremia, documenting Patient F's medication compliance, and ordering and reviewing follow up lab tests to monitor potential virus suppression or mutation.[46]

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[43] All protease inhibitors must be taken concurrently with Ritonavir in order to achieve adequate efficacy.

[44] The standard of care dictates that all patients starting Abacavir should be tested for the HLA-B*5701 allele. If a patient tests positive for the HLA-B*5701 allele, then Abacavir is contraindicated.

[45] The standard of care dictates that Emtricitabine (found in Truvada) and Lamivudine (found in Epzicom) should not be prescribed together because they have similar resistance profiles.

[46] The standard of care dictates that for a patient who is viremic (i.e. the virus is present in the blood) while

## SECOND CAUSE FOR DISCIPLINE
**(Repeated Negligent Acts)**

116. Respondent has further subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patients A, B, C, D, E, and F, as more particularly alleged hereinafter:

117. Paragraphs 10 through 115, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

118. Respondent committed repeated negligent acts in the care and treatment of Patient A for the following:

a. Paragraph 110 is hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to document the consideration of the drug interaction between Seroquel and Stribild;[47] and

c. Failing to explain and document the justification for switching Patient A from Stribild to Reyataz, Epzicom, and Norvir.

119. Respondent committed repeated negligent acts in the care and treatment of Patient B for the following:

a. Paragraph 111 is hereby incorporated by reference and re-alleged as if fully set forth herein; and

b. Failing to document the consideration of the drug interaction between Seroquel and Stribild.

120. Respondent committed repeated negligent acts in the care and treatment of Patient C for the following:

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on ART should be evaluated to determine the reasons for observed viremia. Those reasons could include medication noncompliance or drug resistance, and should be documented in the medical record. HIV management guidelines from the NIH and the American Academy of HIV Medicine also dictate that HIV viral load should be measured at the initial visit, at ART initiation or modification, and every three (3) to six (6) months thereafter.

[47] Quetiapine (Seroquel) levels are increased when used with the protease inhibitors Darunavir and Elvitegravir. If a patient was previously taking Quetiapine, the standard of care dictates that the Quetiapine dose should have been reduced to 1/6 the original strength when adding a protease inhibitor to a patient's ART regimen.

a. Paragraph 112 is hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to document the consideration of the drug interaction between Seroquel and Stribild;

c. Failing to routinely monitor Patient C's renal function and chemistries while being prescribed Tenofovir; and

d. Failing to explain and document the justification for switching Patient C from Prezista, Norvir, and Truvada to Stribild.

121. Respondent committed repeated negligent acts in the care and treatment of Patient D for the following:

a. Paragraph 113 is hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to document the consideration of the drug interaction between Seroquel and Stribild;

c. Failing to routinely monitor Patient D's renal function and chemistries while being prescribed Tenofovir;

d. Failing to explain and document the justification for switching Patient D from Stribild to Tivicay, Norvir, and Truvada; and

e. Failing to properly document the medical indications and prescriptions for Hydrocodone and Oxycodone.

122. Respondent committed repeated negligent acts in the care and treatment of Patient E for the following:

a. Paragraph 114 is hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to document lab results and medical decision making at Patient E's initial visit;

c. Failing to document the consideration of the drug interaction between Seroquel and Stribild;

d. Failing to explain and document the justification for switching Patient E from Prezista, Isentress, and Truvada to Atripla to Stribild then Triumeq; and

e. Failing to properly document the medical indication for prescribing Oxycodone.

123. Respondent committed repeated negligent acts in the care and treatment of Patient F for the following:

a. Paragraph 115 is hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent prescribed Patient F Abacavir without documenting current or previous HLA-B*5701 testing;

c. Respondent failed to verify or document Patient F's Hepatitis B infection status or serology; and

d. Respondent failed to document the consideration of the drug interaction between Seroquel and Stribild.

**THIRD CAUSE FOR DISCIPLINE**
**(Violating State and/or Federal Statutes Governing Dangerous Drugs)**

124. Respondent has further subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that he violated state and/or federal statutes regulating dangerous drugs, as more particularly alleged in paragraph 107, above, which is hereby incorporated by reference and re-alleged as if fully set forth herein.

**FOURTH CAUSE FOR DISCIPLINE**
**(Use or Prescribing for or Administering to Himself Any Controlled Substance)**

125. Respondent has further subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234, as defined by section 2239, of the Code, in that he repeatedly self-prescribed a controlled substance, as more particularly alleged in paragraph 107, above, which is hereby incorporated by reference and re-alleged as if fully set forth herein.

## FIFTH CAUSE FOR DISCIPLINE
**(Failure to Maintain Adequate and Accurate Records)**

126. Respondent has further subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234, as defined by 2266, of the Code, in that he failed to maintain adequate and accurate records for Patients A, B, C, D, E, and F, as more particularly alleged in paragraphs 10 through 123, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

## SIXTH CAUSE FOR DISCIPLINE
**(General Unprofessional Conduct)**

127. Respondent has further subjected his Physician's and Surgeon's Certificate No. C50556 to disciplinary action under sections 2227 and 2234 of the Code, in that he committed general unprofessional conduct for the care and treatment of Patients A, B, C, D, E, and F, and for self-prescribing controlled substances, as more particularly alleged in paragraphs 10 through 126, above, which are hereby incorporated by reference and re-alleged 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. C50556, issued to Respondent Mohamed W. El-Nachef, M.D.;

2. Revoking, suspending or denying approval of Respondent Mohamed W. El-Nachef, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Mohamed W. El-Nachef, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 16, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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