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

In the Matter of the First Amended Accusation Against: **Nathan Stuart Howard, M.D.** **Physician's and Surgeon's Certificate No. A 75819** **Respondent.**	**Case No. 800-2016-028521**

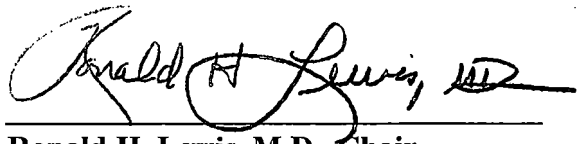
DECISION

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 July 9, 2020.

IT IS SO ORDERED: June 9, 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
ROSEMARY F. LUZON
Deputy Attorney General
State Bar No. 221544
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9074
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **NATHAN STUART HOWARD, M.D.** **850 E. Latham Avenue, #205** **Hemet, CA 92543** **Physician's and Surgeon's Certificate No. A 75819,** Respondent.	Case No. 800-2016-028521 OAH No. 2019071091 **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). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rosemary F. Luzon, Deputy Attorney General.

///

2. Respondent Nathan Stuart Howard, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: Doyle Schafer McMahon, LLP, 5440 Trabuco Rd., Irvine, CA 92620.

3. On or about July 12, 2001, the Board issued Physician's and Surgeon's Certificate No. A 75819 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2016-028521, and will expire on July 31, 2021, unless renewed.

JURISDICTION

4. On or about October 25, 2019, First Amended Accusation No. 800-2016-028521 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on or about October 25, 2019, at his address of record. Respondent timely filed his Notice of Defense contesting the First Amended Accusation. A true and correct copy of First Amended Accusation No. 800-2016-028521 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2016-028521. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

///

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

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2016-028521, a copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 75819 to disciplinary action.

9. Respondent agrees that if he ever petitions for early termination or modification of this Stipulated Settlement and Disciplinary Order, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2016-028521 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A 75819 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. This Stipulated Settlement and Disciplinary Order shall be subject to approval by 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 shall assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 75819 issued to Respondent Nathan Stuart Howard, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months from the effective date of the Decision on the following terms and conditions.

///

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

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

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

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

///

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

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

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

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, 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 and First Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of

receipt of the Decision, First Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and First Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

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

The monitor 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 the practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

///

///

///

///

///

///

///

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

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

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

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

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

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

8. 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.

9. 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.

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.

10. 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.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

///

///

///

///

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

12. 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.

13. 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.

14. 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 license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

///

///

15. 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, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 75819. 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: 2/13/20

NATHAN STUART HOWARD, M.D.
Respondent

I have read and fully discussed with Respondent Nathan Stuart Howard, 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: February 13, 2020

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

///
///
///
///
///
///
///

ENDORSEMENT

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

DATED: 2/18/20

Respectfully submitted,

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

ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant

SD2019700591
72114837.docx

Exhibit A

First Amended Accusation No. 800-2016-028521

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
ROSEMARY F. LUZON
Deputy Attorney General
State Bar No. 221544
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9074
Facsimile: (619) 645-2061

Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 25 2019
BY A. Geremia ANALYST

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

In the Matter of the First Amended Accusation Against: **Nathan Stuart Howard, M.D.** **850 E. Latham Avenue, #205** **Hemet, CA 92543** **Physician's and Surgeon's Certificate No. A 75819,** Respondent.	Case No. 800-2016-028521 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended 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 July 12, 2001, the Medical Board issued Physician's and Surgeon's Certificate No. A 75819 to Nathan Stuart Howard, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

JURISDICTION

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

4. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . ."

5. Section 2227 of the Code states:

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

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

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

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

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

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

". . ."

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

". . ."

7. Section 2266 of the Code states:

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 75819 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 his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

///

[1] References to "Patient A" and "Patient B" herein are used to protect patient privacy.

9. On or about April 2, 2012, Patient A commenced treatment with Respondent for her primary care needs.[2] Patient A's medical history included fibromyalgia and neuropathy, among other medical conditions. Respondent also noted past alcohol use, but no current usage, and that her last alcoholic drink was "2 years ago." During this visit, Respondent prescribed Norco (hydrocodone acetaminophen)[3] and temazepam[4] to Patient A.

10. On or about June 8, 2012, October 3, 2012, January 15, 2013, February 12, 2013, October 18, 2013, and November 1, 2013, respectively, Patient A had a follow-up visit with Respondent. During these visits, Respondent documented Patient A's fibromyalgia, describing it as either chronic or acute, and noted Patient A's complaints of "aching" or "increased" pain related to her fibromyalgia.

11. During the November 1, 2013, visit, Patient A complained of neuropathic pain in her feet and reported that she had neuropathy when she was in the hospital in 2011. Respondent noted Patient A's functional limitations, including in her inability to exercise, kneel, and walk unlimited distances, as well as her difficulty to perform activities of daily living. Respondent again noted that Patient A did not currently use alcohol and that her last alcoholic drink was "2 years ago."

12. Between on or about June 4, 2012, and December 2, 2013, Respondent continued to prescribe Norco to Patient A on a near monthly basis as follows:

MEDICATION NAME	START DATE
Norco 10 mg-325 mg Tab	June 4, 2012
Norco 10 mg-325 mg Tab	July 2, 2012
Norco 10 mg-325 mg Tab	August 1, 2012
Norco 10 mg-325 mg Tab	October 2, 2012
Norco 10 mg-325 mg Tab	November 5, 2012
Norco 10 mg-325 mg Tab	November 29, 2012

[2] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant First Amended Accusation is described for informational purposes only and not pleaded as a basis for disciplinary action.

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

[4] Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

MEDICATION NAME	START DATE
Norco 10 mg-325 mg Tab	January 2, 2013
Norco 10 mg-325 mg Tab	January 15, 2013
Norco 10 mg-325 mg Tab	March 5, 2013
Norco 10 mg-325 mg Tab	April 2, 2013
Norco 10 mg-325 mg Tab	May 2, 2013
Norco 10 mg-325 mg Tab	May 29, 2013
Norco 10 mg-325 mg Tab	July 2, 2013
Norco 10 mg-325 mg Tab	August 5, 2013
Norco 10 mg-325 mg Tab	September 3, 2013
Norco 10 mg-325 mg Tab	September 30, 2013
Norco 10 mg-325 mg Tab	November 1, 2013
Norco 10 mg-325 mg Tab	December 2, 2013

13. Between on or about June 5, 2012, and December 2, 2013, Respondent also continued to prescribe temazepam to Patient A as follows:

MEDICATION NAME	START DATE
temazepam 30 mg Cap	June 5, 2012
temazepam 30 mg Cap	August 1, 2012
temazepam 30 mg Cap	February 4, 2013
temazepam 30 mg Cap	May 2, 2013
temazepam 30 mg Cap	May 29, 2013
temazepam 30 mg Cap	August 2, 2013
temazepam 30 mg Cap	August 5, 2013
temazepam 30 mg Cap	September 3, 2013
temazepam 30 mg Cap	December 2, 2013

14. On or about December 30, 2013, the paramedics brought Patient A to the hospital emergency room after she was found on the ground. According to the History and Physical Exam record, Patient A was confused and did not know what happened to her and why she was in the hospital. Patient A reported that she was heavily using alcohol and that her last drink was three days earlier. The attending physician assessed Patient A as having "[a]lcohol withdrawal with possible delirium and increased risks of delirium tremens," as well as possible myocardial infarction that needed to be ruled out and possible syncopal episode. Patient A was given medication for alcohol withdrawal and monitored for delirium tremens. A copy of the History and Physical Exam record was faxed to Respondent on or about January 10, 2014.

15. On or about January 10, 2014, Respondent prescribed Norco to Patient A. Patient A filled this prescription on or about the same day.

///

///

16. On or about January 25, 2014, Respondent prescribed temazepam to Patient A. Two refills were authorized by Respondent, which Patient A filled on or about February 28, 2014, and April 1, 2014, respectively.

17. On or about January 31, 2014, Patient A had an office visit with Respondent following her hospitalization. Respondent noted that Patient A was hospitalized "due to [sic] heartattack," but Respondent did not mention the alcohol issues discussed in the December 30, 2013, History and Physical Exam record. Instead, Respondent again noted that Patient A had no current alcohol usage and that her last alcoholic drink was "2 years ago." Respondent continued Patient A on Norco.

18. On or about February 3, 2014, Respondent prescribed Norco to Patient A. Patient A filled this prescription on or about February 8, 2014.

19. On or about February 21, 2014, Patient A went to the hospital emergency room after falling on her face two days earlier. According to the Emergency Room Report, Patient A had "[a]cute alcohol intoxication," with an alcohol level of 291 mg/dl. Patient A was admitted to the hospital "to the service of [Respondent] for further evaluation and treatment."

20. On or about February 26, 2014, while still in the hospital, Patient A had a consultation for "[a]lcohol problems." According to the Consultation Report, Patient A was assessed to have chronic alcohol dependence and chronic opiate dependence. The consulting physician recommended that Patient A go to a recovery center for her alcohol problems, but advised that she must stop her use of opiates and benzodiazepines in order to do so. Patient A was unsure and stated that she would discuss the matter with her primary care physician. A copy of the Consultation Report was faxed to Respondent on or about March 1, 2014.

21. On or about February 26, 2014, Patient A had a second consultation for "[a]lcohol liver disease," among other problems. According to the Consultation Report, Patient A was assessed to have "[a]lcoholism and alcoholic liver disease, probably cirrhosis." The consulting physician discussed the physician's impressions and recommendations with Respondent. A copy of the Consultation Report was faxed to Respondent on or about March 8, 2014.

///

22. On or about March 3, 2014, Respondent discharged Patient A from the hospital. According to Respondent's Discharge Summary, one of the principal diagnoses was "[a]lcoholism." Respondent noted Patient A's history of alcohol abuse, her alcoholism three days prior to admission, her altered level of consciousness when she presented to the emergency room, that she had a chemical dependency consult, and that the consulting physician recommended she go to outpatient treatment for her alcoholism.

23. On or about March 24, 2014, Respondent prescribed Norco to Patient A. Patient A filled this prescription on or about the same day.

24. Throughout Respondent's care and treatment of Patient A, Respondent did not adequately assess or document Patient A's prior treatment for chronic pain.

25. Throughout Respondent's care and treatment of Patient A, Respondent did not adequately assess or document the basis for diagnosis of Patient A's chronic pain by, *inter alia*, obtaining an adequate medical history of Patient A's fibromyalgia, performing an adequate physical exam, and ordering adequate diagnostic testing to determine if other identifiable diagnoses existed to explain Patient A's symptoms.

26. Throughout Respondent's care and treatment of Patient A, until on or about November 1, 2013, Respondent did not assess Patient A's functionality in relation to her chronic pain.

27. Throughout Respondent's care and treatment of Patient A, Respondent did not refer Patient A for any further evaluation and treatment of her chronic pain, including physical therapy.

28. Throughout Respondent's care and treatment of Patient A, Respondent did not discuss the risks and benefits of using Norco and temazepam with Patient A.

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

(a) Respondent continued to prescribe Norco and temazepam to Patient A despite evidence of Patient A's alcohol abuse.

///

///

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

30. Respondent has subjected his Physician's and Surgeon's Certificate No. A 75819 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 his care and treatment of Patient A and Patient B, as more particularly alleged hereinafter:

Patient A

31. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but were not limited to the following:

(a) Paragraphs 9 through 29, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

(b) Respondent did not adequately assess or document Patient A's prior treatment for chronic pain or the basis for diagnosis of Patient A's chronic pain;

(c) Respondent did not timely assess Patient A's functionality in relation to her chronic pain and did not refer Patient A for any further evaluation and treatment of her chronic pain, including physical therapy; and

(d) Respondent did not discuss the risks and benefits of using Norco and temazepam with Patient A.

Patient B

32. On or about November 20, 2012, Patient B saw Respondent for the first time to establish care. Patient B complained of pelvic pain during this visit. Respondent documented few details concerning Patient B's reported pelvic pain and he did not document any examination of Patient B's pelvis or lower extremities specifically. According to the Physical Exam section of Respondent's notes, Respondent's findings were as follows: "Constitutional: No apparent distress. Well nourished and well developed. Head/Face: Normocephalic. Integumentary: No impressive skin lesions are present. Back/Spine: No kyphosis or scoliosis. Extremities: Extremities appear normal. No edema or cyanosis. Neurological: Alert and oriented. Psychiatric: No unusual anxiety or evidence of depression."

33. On or about January 23, 2013, Patient B saw Respondent for a follow-up visit. In addition to complaining of a dry cough, Patient B reported having paranoid delusions, a history of hospitalization, and feeling persecuted. Respondent documented few details concerning Patient B's reported delusions and hospitalization, and he repeated verbatim all of his findings from the November 20, 2012, physical exam, including his assessment of Patient B's psychiatric state as exhibiting "[n]o unusual anxiety or evidence of depression." Despite this assessment, Respondent diagnosed Patient B as having acute paranoia and referred her to psychiatry.

34. On or about April 16, 2013, June 10, 2013, and August 9, 2013, respectively, Patient B saw Respondent for multiple issues, including urinary tract infection, hypertension, vaginal cyst, and paranoia. For each of these visits, Respondent repeated verbatim all of his findings from the November 20, 2012, and January 23, 2013, physical exam, including his assessment of Patient B's psychiatric state as exhibiting "[n]o unusual anxiety or evidence of depression." During the visit that took place on or about April 16, 2013, Respondent noted that Patient B complained of paranoia and that she did not see a psychiatrist. No other details regarding Patient B's reported paranoia were noted. Respondent re-referred Patient B to psychiatry for chronic paranoid behavior.

35. Between on or about November 5, 2013, and March 28, 2014, Patient B saw Respondent on approximately five occasions. For each of these visits, Respondent repeated verbatim his prior assessment of Patient B's psychiatric state as exhibiting "[n]o unusual anxiety or evidence of depression."

36. During the visit that took place on or about March 28, 2014, Patient B complained of left knee pain. Other than noting that the pain was "aching," did not radiate, and was accompanied by tenderness, Respondent documented few other details concerning Patient B's reported left knee pain. In the Physical Exam section of Respondent's notes, specifically the musculoskeletal assessment, Respondent's only notation regarding Patient B's knee pain was that the "[l]eft knee has tenderness."

37. On or about April 22, 2014, Patient B followed up with Respondent regarding worsening left knee pain. Patient B described the pain as constant, aching, and sharp, with a

severity level of "9," and that it was aggravated by walking and standing and was relieved by pain medications. Patient B reported going to "Ortho" and being diagnosed with arthritis. In the Physical Exam section of Respondent's notes, specifically the musculoskeletal assessment, Respondent repeated verbatim his prior assessment of Patient B's knee pain, *i.e.*, that the "[l]eft knee has tenderness."

38. On or about June 3, 2014, Patient B saw Respondent following an emergency room visit due to left leg pain and swelling. Respondent documented few details concerning Patient B's reported leg complaints and emergency room visit. In the Physical Exam section of Respondent's notes, specifically the musculoskeletal assessment, Respondent's only notation regarding Patient B's left leg issues was that the "[l]eft knee has swelling."

39. On or about August 11, 2015, Patient B re-established care with Respondent. Patient B presented with hypertension, thyroid disease, and complained of a possible hernia. Respondent documented few details concerning Patient B's possible hernia. Respondent did not document anything regarding abdominal pain, heartburn, belching, or bowel function. Nor did Respondent document performing an abdominal examination or any assessment of possible hernia. Respondent's diagnosis was chronic GERD (gastroesophageal reflux disease) and he prescribed Pepcid to Patient B. During this visit, Respondent described Patient B's psychiatric state as follows: "Orientation – Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment."

40. On or about September 28, 2015, Patient B had a follow-up visit with Respondent. During this visit, Patient B requested stool softener. Respondent documented few details concerning Patient B's request. Respondent did not document performing an abdominal examination and he repeated verbatim all of his prior findings from the August 11, 2015, physical exam, including his assessment of Patient B's psychiatric state as normal. Respondent diagnosed Patient B with constipation and he prescribed Colace to her.

41. On or about October 27, 2015, Patient B saw Respondent again and complained of cold symptoms and constipation. Respondent did not document performing an abdominal examination. He also repeated verbatim his prior assessment of Patient B's psychiatric state as

normal. Respondent diagnosed Patient B with chronic ventral hernia and ordered a CT scan of the abdomen as well as laboratory testing. He prescribed Senokot to Patient B for constipation.

42. On or about November 19, 2015, Patient B had a CT scan of her abdomen and pelvis. The CT scan revealed a midline anterior abdominal wall hernia and a small hiatal hernia. On or about December 3, 2015, Patient B saw Respondent to follow up on the CT scan results, laboratory results, and constipation. Respondent's diagnosis was recurrent ventral hernia and his plan was to observe this condition. During this visit, Respondent repeated verbatim his prior assessment of Patient B's psychiatric state as normal.

43. On or about January 11, 2016, Patient B had a follow-up visit with Respondent. Patient B requested hernia surgery. Respondent documented few details concerning Patient B's request. Respondent did not document performing an abdominal examination and he repeated verbatim his prior assessment of Patient B's psychiatric state as normal.

44. Between on or about February 22, 2016, and October 20, 2016, Patient B saw Respondent on approximately 8 occasions. During a visit that took place on or about March 24, 2016, Patient B reported to Respondent that she was having hallucinations, prompting Respondent to refer her for a psychiatric consultation. Respondent documented few details concerning Patient B's reported hallucinations on this visit. In addition, between on or about March 27, 2016, and March 30, 2016, Patient B was hospitalized for psychiatric reasons, during which she was diagnosed with paranoid schizophrenia, among other diagnoses. Respondent attended to Patient B during her hospitalization and discharged her. Despite this history, between on or about March 24, 2016, and October 20, 2016, Respondent continued to repeat verbatim his prior assessment of Patient B's psychiatric state as normal.

///

///

///

///

///

///

45. Respondent committed repeated negligent acts in his care and treatment of Patient B, which included, but were not limited to the following:

(a) Respondent failed to properly document multiple key aspects of Patient B's visits involving complaints of pelvic pain, left knee pain, gastrointestinal issues (*i.e.*, hernia, constipation, and GERD), and psychiatric issues, including the history of Patient B's complaints, the examinations actually performed to assess the complaints and the results thereof, and the existence and nature of Patient B's psychiatric problems.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

46. Respondent has subjected his Physician's and Surgeon's Certificate No. A 75819 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 9 through 45, 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. A 75819, issued to Respondent Nathan Stuart Howard, M.D.;

2. Revoking, suspending or denying approval of Respondent Nathan Stuart Howard, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Nathan Stuart Howard, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

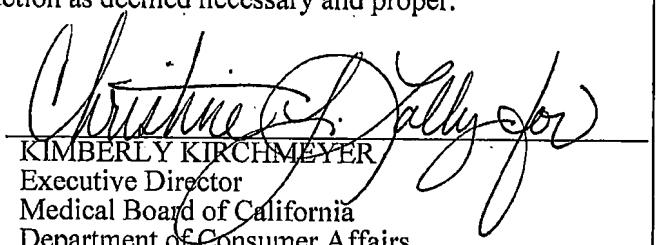
///

///

///

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

DATED: October 25, 2019



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

SD2019700591
71991552.docx