ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
ANA GONZALEZ
Deputy Attorney General
State Bar No. 190263
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3608
Facsimile: (415) 703-5480
E-mail: Ana.Gonzalez@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against, **ROBERT CHARLES HIEMSTRA, M.D.** 3286 E. Danish Hills Circle Salt Lake City, UT 84121 **Physician's and Surgeon's Certificate No. G 27113** Respondent.	Case No. 800-2020-070709 OAH No. 2021040671 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about February 25, 2021, Complainant William Prasifka, in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 800-2020-070709 against Robert Charles Hiemstra, M.D. (Respondent) before the Medical Board of California.

2. On or about July 1, 1974, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 27113 to 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, 2022, unless renewed. (Exhibit Package, Exhibit 1[1], license certification.)

3. On or about February 25, 2021, an employee of the Board served by Certified Mail a copy of the Accusation No. 800-2020-070709, Statement to Respondent, Notice of Defense in blank, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3286 E. Danish Hills Circle Salt Lake City, UT 84121. (Exhibit Package, Exhibit 2, Accusation Packet, proof of service; Exhibit 3, USPS tracking printout; Exhibit 4, Medical Board Printout of Address of Record as of June 4, 2021.)

4. On or about March 22, 2021, Complainant received Respondent's Notice of Defense, requesting a hearing in this matter. (Exhibit Package, Exhibit 5, Notice of Defense.)

5. On April 9, 2021, counsel for Complainant emailed Respondent proposed hearing dates, using the email address listed in Respondent's Notice of Defense. On April 16, 2021, counsel for Complainant called Respondent, using the phone number listed in the Notice of Defense, and left a message asking for a response on the proposed hearing dates. On April 16, 2021, Respondent called back, apologized for the delay, and indicated he would respond with dates for the hearing. On April 17, 2021, Respondent an email to counsel for Complainant, agreeing to the hearing date of June 3, 2021. On April 19, 2021, Respondent and counsel for Complaint communicated by phone and discussed, among other things, that the hearing would likely be set as a remote (video) hearing rather than an in person hearing. (Exhibit Package, Exhibit 6, Declaration of Deputy Attorney General Ana Gonzalez.)

6. On or about April 22, 2021, a Notice of Hearing was sent by certified mail to Respondent's address of record and by email to the email address listed by Respondent in the Notice of Defense. The Notice informed Respondent that an administrative hearing in this matter was scheduled for June 3, 2021. (Exhibit Package, Exhibit 7, Notice of Hearing, proof of service; Exhibit 8, USPS tracking printout.)

---

[1] The evidence in support of this Default Decision and Order is submitted herewith as the "Exhibit Package."

7. On April 29, 2021, Respondent emailed counsel for Complainant and confirmed receipt of the Notice of Hearing. (Exhibit Package, Exhibit 6, Declaration of Deputy Attorney General Ana Gonzalez.)

8. On May 12, 2021, a Notice of Order re Remote Hearing was sent by certified mail to Respondent's address of record and by email, to the email address listed by Respondent in the Notice of Defense, informing him the administrative hearing scheduled for June 3, 2021, would be conducted remotely, by video and/or phone. The order from the Office of Administrative Hearings was attached to the notice and included instructions on how to appear by phone and upload any exhibits. (Exhibit Package, Exhibit 9, Notice of Order re Remote Hearing, proof of service; Exhibit 10, USPS tracking printout.)

9. On May 25, 2021, the Office of Administrative Hearings sent a Microsoft Teams video link for the hearing to both counsel for Complaint's email address and Respondent's email address, as listed on his Notice of Defense. (Exhibit Package, Exhibit 6, Declaration of Deputy Attorney General Ana Gonzalez.)

10. Respondent did not appear at the June 3, 2021, hearing by either phone or video. The administrative law judge took a break to give the Respondent an opportunity to appear. During the break, counsel for Complainant called Respondent on the phone number previously used to communicate. A person that sounded like Respondent answered the phone but hung up as soon as counsel for Complainant identified herself. Counsel for Complainant called again, this time the phone call was not answered, and left a voicemail message indicating the hearing was scheduled for that morning. (Exhibit Package, Exhibit 6, Declaration of Deputy Attorney General Ana Gonzalez.)

11. The Administrative Law Judge found that proper notice of the hearing had been provided, and Respondent was declared to be in default. (Exhibit Package, Exhibit 11, Findings and Declaration of Default; Order of Remand.)

12. The allegations of the Accusation are true as follows:

On August 31, 2020, the Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (Utah Licensing Division), imposed discipline on

Respondent's Utah Physician and Surgeon license. Respondent was placed on a three-year probation with extensive requirements, including practicing only under the general supervision of a physician approved by the Utah Licensing Division. The discipline was based on stipulated facts that Respondent violated standards of professional behavior in the administration of the controlled substance Ketamine. In summary, over the course of a year he administered and prescribed Ketamine in a non-FDA approved/off label manner, he failed to properly diagnose and evaluate patients before administering the Ketamine, he failed to provide proof of signed consent, failed to have access to an advanced cardiac life support crash cart while administering Ketamine (for a portion of that time), failed to adequately monitor patient's oxygenation and circulation while administering Ketamine, and a number of patients left their Ketamine appointment without any type of discharge information or exit evaluation. Further, on at least one occasion he left a patient, with a Ketamine IV drip, alone in the medical clinic such that the patient had to remove the IV herself and call the police, he responded to another patient's negative internet review in an inappropriate manner and, on at least two occasions refused to accept and review medical records his patient offered him prior to treatment. A copy of the Utah Licensing Division Stipulation and Order is attached to the Accusation in this matter. (Exhibit Package, Exhibit 2, Accusation Attachment A.)

STATUTORY AUTHORITY

13. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

14. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

15. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

DETERMINATION OF ISSUES

1. The Board has jurisdiction to adjudicate this case by default, and pursuant to Government Code section 11520, finds that Respondent is in default. The Board will take action without further proceedings or hearing and, based on Respondent's admissions by way of default and the evidence before the Board, finds that the allegations in Accusation No. 800-2020-070709, are true and correct.

2. Pursuant to the foregoing Findings of Fact, Respondent's conduct and the action of the Utah Licensing Division constitute cause for discipline within the meaning of Business and Professions Code sections 2305 and 141(a).

DISCIPLINARY ORDER

Physician's and Surgeon's certificate number G 27113 issued to Robert Charles Hiemstra, M.D. is hereby **REVOKED.**

Respondent shall not be deprived of making a request for relief from default as set forth in Government Code section 11520(c) for good cause shown. However, such showing must be made in writing by way of a motion to vacate the default decision and directed to the Medical Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven (7) days of the service of this Decision.

This Decision will become effective at 5:00 p.m. on July 23, 2021.

It is so ordered on June 24, 2021.

WILLIAM PRASIFKA
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

SF2021400126
42723303.docx

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
ANA GONZALEZ
Deputy Attorney General
State Bar No. 190263
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3608
Facsimile: (415) 703-5480
E-mail: Ana.Gonzalez@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Robert Charles Hiemstra, M.D.** **3286 E. Danish Hills Circle** **Salt Lake City, UT 84121** **Physician's and Surgeon's Certificate** **No. G 27113,** Respondent.	Case No. 800-2020-070709 **A C C U S A T I O N**

PARTIES

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

2. On July 1, 1974, the Medical Board issued Physician's and Surgeon's Certificate Number G 27113 to Robert Charles Hiemstra, 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, 2022, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

6. Section 141 of the Code states:

> (a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.
>
> (b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country.

CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

7. On August 31, 2020, the Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (Utah Licensing Division), imposed discipline on Respondent's Utah Physician and Surgeon license. Respondent was placed on a three-year

probation with extensive requirements, including practicing only under the general supervision of a physician approved by the Utah Licensing Division. The discipline was based on stipulated facts that Respondent violated standards of professional behavior in the administration of Ketamine. In summary, over the course of a year he administered and prescribed Ketamine in a non-FDA approved/off label manner, he failed to properly diagnose and evaluate patients before administering the Ketamine, he failed to provide proof of signed consent, failed to have access to an advanced cardiac life support crash cart while administering Ketamine (for a portion of that time), failed to adequately monitor patient's oxygenation and circulation while administering Ketamine, and a number of patients left their Ketamine appointment without any type of discharge information or exit evaluation. Further, on at least one occasion he left a patient, with a Ketamine IV drip, alone in the medical clinic such that the patient had to remove the IV herself and call the police, he responded to another patient's negative internet review in an inappropriate manner and, on at least two occasions refused to accept and review medical records his patient offered him prior to treatment. A copy of the Utah Licensing Division Stipulation and Order is attached as Exhibit A.

8. Respondent's conduct and the action of the Utah Licensing Division as set forth in paragraph 7, above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the Code

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 27113, issued to Robert Charles Hiemstra, M.D.;

2. Revoking, suspending or denying approval of Robert Charles Hiemstra, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert Charles Hiemstra, 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: FEB 25 2021

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

SF2021400126
42523595.docx

Attachment A

Utah Licensing Division Stipulation and Order

State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

GARY R. HERBERT
Governor
SPENCER J. COX
Lieutenant Governor

CHRIS PARKER
Executive Director

MARK B. STEINAGEL
Division Director

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

OF THE DEPARTMENT OF COMMERCE

OF THE STATE OF UTAH

State of Utah	ss.	Robert Charles Hiemstra, MD Case No. DOPL-2019-477
County of Salt Lake		

I hereby certify that the attached documents consist of a true and correct copy of the original records contained in the Division's August 31, 2020 Stipulation and Order and November 14, 2019 Notice of Agency Action and Petition in the above-entitled matter or cause, now of record or on file in the office of the Division of Occupational and Professional Licensing of the State of Utah.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said Division this 22 day of September 2020.

Carol W. Inglesby
Administrative Assistant

www.dopl.utah.gov • Heber M. Wells Building • 160 East 300 South • P.O. Box 146741 • Salt Lake City, UT 84114-6741
telephone (801) 530-6628 • toll-free in Utah (866) 275-3675 • fax (801) 530-6511 • investigations fax (801) 530-6301

UTAH
LIFE ELEVATED

Dan Lau (USB No. 8233)
Assistant Attorney General
SEAN D. REYES (USB No. 7969)
Utah Attorney General
Commercial Enforcement Division
Heber M. Wells Building
Box 140872
Salt Lake City, UT 84114-6741
TEL: (801) 366-0310

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

OF THE DEPARTMENT OF COMMERCE

OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSES OF **ROBERT CHARLES HIEMSTRA** UTAH LICENSE #333085-1205 & -8905 TO PRACTICE AS A PHYSICIAN AND TO ADMINISTER AND PRESCRIBE CONTROLLED SUBSTANCES IN THE STATE OF UTAH	)))))))	**STIPULATION AND ORDER** CASE NO. DOPL 2019- 477

ROBERT CHARLES HIEMSTRA ("Respondent") and the **DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING** of the Department of Commerce of the State of Utah ("Division") stipulate and agree as follows:

1. The Respondent admits the jurisdiction of the Division over the Respondent and over the subject matter of this action.

2. The Respondent acknowledges that he enters into this Stipulation and Order ("Stipulation") knowingly and voluntarily.

3. The Respondent understands that he has the right to be represented by counsel in this matter, and his signature below signifies that he has consulted with his attorneys, Greg Soderberg and Joshua Irvine, in this matter.

4. The Respondent understands that he is entitled to participate in a hearing before the State of Utah's Physician Licensing Board, or other Division Presiding Officer, at which time the Respondent may present evidence on his own behalf, call witnesses, and confront adverse witnesses. The Respondent understands that by signing this document he hereby knowingly and intelligently waives the right to participate in a hearing, to present evidence on his own behalf, to call witnesses, to confront adverse witnesses, and any other rights to which he may be entitled in connection with said hearing. The Respondent understands that by signing this document he waives all rights to any administrative and judicial review as set forth in Utah Code Ann. §§ 63G-4-301 through 63G-4-405 and Utah Administrative Code R156-4-901 through R156-4-907. The Respondent and the Division hereby express their intent that this matter be resolved expeditiously through stipulation as contemplated in Utah Code Ann. § 63G4-102(4).

5. The Respondent understands that this Stipulation, if adopted by the Director of the Division, will be classified as a public document. The Division may release this Stipulation, and will release other information about this disciplinary action against Respondent's license, to other persons and entities.

6. Respondent admits the following facts are true:

   a. The Respondent was first licensed to practice as a physician and to administer and prescribe controlled substances in the State of Utah on or about May 27, 1997.

b. Between May 2018 and August 2018, on multiple occasions in the State of Utah, the Respondent administered or prescribed the drug Ketamine, a Schedule III controlled substance, for purposes of the treatment of mental health disorders, including depression, in a non-FDA approved/off label manner.

c. Ketamine, outside of a nasal form (esketamine), has not been approved by the U.S. Food and Drug Administration for use on humans for the treatment of mental health disorders, and is considered an experimental treatment. Using Ketamine in a non-FDA approved manner is also considered an off-label use of the drug.

d. On multiple occasions in the time period named in provision 7b, the Respondent failed to provide proof that he obtained information from patients sufficient to establish a diagnosis, identify conditions, and identify contraindications before administering or prescribing Ketamine.

e. On a number of occasions in the time period named in provision 7b, the Respondent failed to provide proof of signed informed consent for Ketamine for depression patients. For at least part of the same time period, the Respondent also failed to have access to an advanced cardiac life support crash cart while administering Ketamine. The Respondent recently purchased, on or about February 2019, an advanced cardiac life support crash cart and has it available for patients.

f. During the time period named in provision 7b, the Respondent failed to adequately monitor patient's oxygenation, ventilation, and circulation while administering Ketamine.

g. During the time period named in provision 7b, the Respondent failed to accept medical records on at least two occasions from a patient who offered her medical records to him.

h. During the time period named in provision 7b, the Respondent responded to a Google Review by a former patient in an inappropriate manner.

i. During the time period named in provision 7b, a number of the Respondent's patients left their Ketamine appointments without any type of discharge information or without anyone checking them out from the Respondent's facility.

j. On or about March 6, 2017, the Respondent left a patient who was receiving Ketamine as treatment for her depression alone in a medical clinic in

Kaysville with an IV in her arm. This patient removed the IV herself, and the police were called to respond to the incident.

8. The Respondent admits that his conduct described above is unprofessional conduct as defined in Utah Code Ann. § 58-1-501(2)(a), (b), (g), (k) and (m). The Respondent agrees by engaging in such conduct the Division is justified in taking disciplinary action against the Respondent's licenses pursuant to Utah Code Ann. § 58-1-401(2)(a) and (b). The Respondent agrees that an Order, which constitutes disciplinary action against the Respondent's licenses by the Division pursuant to Utah Administrative Code R156-1-102(7) and Utah Code Ann. § 58-1-401(2), may be issued in this matter providing for the following action against the Respondent's licenses:

(1) The Respondent's licenses to practice as a physician/surgeon and to administer and prescribe controlled substances in the State of Utah shall be revoked, and the revocations shall be immediately stayed. The Respondent's licenses will immediately be subject to a term of probation for a period of three years. The period of probation shall commence when the Division Director signs the Order in this matter. During the period of probation, the Respondent's license shall be subject to all of the following terms and conditions. If the Board or Division later deems any of the conditions unnecessary such deletions may be made by an amended order issued unilaterally by the Division and Board. The Respondent will, however, be required to continue his treatment of Ketamine patients with the following minimum conditions for as long as he treats mental health patients with Ketamine: he will employ two APRN's (one of them being a CRNA) for his Ketamine treatment of patients, he will require PCP paperwork from potential Ketamine patients (when available), he will continue to screen potential Ketamine patients for drug use, contraindicative conditions and the appropriateness of Ketamine for depression treatment; he will continue to have video monitoring in each treatment room, he will continue to use Caretaker equipment for each Ketamine patient, and he will continue to have set and firm discharge policies and procedures in place for Ketamine patients. If the Respondent meets all probationary requirements, he may apply for early termination of his probationary period after 18 months from the effective date of this Stipulation.

a. The Respondent shall meet with the Division and Board within thirty (30) days of the signing of the accompanying Order. The Respondent shall meet with a Division staff person prior to his first meeting with the Board to review this agreement. For the remainder of the duration of probation, the Respondent shall meet with the Board or with the Division, as directed by the Division or Board, quarterly or at such other greater or lesser frequency as the Division or Board may direct.

b. Failure of the Respondent to pay the costs associated with this Stipulation constitutes a violation of the Stipulation.

c. All reports and documentation required in this Stipulation and Order shall be submitted to the Division and Board on a monthly basis for the first six months of probation. If the Respondent is in compliance with all terms and conditions of the Order at the end of that time, all reports and documentation shall be submitted on a quarterly basis for the remainder of probation. If the Respondent is not in compliance with all terms and conditions of the Order by the end of the first six (6) months of probation, all reports and documentation shall be submitted on a monthly basis until Respondent is in compliance with the Order, after which all reports shall be submitted on a quarterly basis.

d. The Respondent shall notify any employer or practice associate of the Respondent's restricted status and the terms of this agreement. The Respondent shall cause his employer to provide periodic reports summarizing the Respondent's compliance with the terms and conditions of this Stipulation at a frequency described in subparagraph (c) above.

e. The Respondent shall promptly and successfully complete the following continuing medical education courses:

--proper medical documentation of care,
--risk management;
--patient discharge policies and procedures;
--professionalism/respect towards patients.

These courses shall be pre-approved by the Division and Board. These courses shall be completed within one year of the effective date of this Stipulation. The Respondent shall promptly provide the Division with documentation showing successful completion of these courses, with the deadline for submission of

course completions being one year from the effective date of this Stipulation.

f. The Respondent shall work under the general supervision of a physician supervisor pre-approved by the Division and Board. The Respondent shall meet weekly with his supervisor unless the Board or Division determines a different frequency. These meetings can be done telephonically unless the Division, Board or the Respondent's supervisor feels that they need to be in person. The focus of supervision shall include concurrent management, proper supervision of employees, and proper delegation, proper supervision/monitoring of patients, proper screening of Ketamine patients, and any other issues the supervisor determines are pertinent to professional and ethical practice. The supervisor shall review 20% of Respondent's patient records. The supervisor, not Respondent, shall select which patient records shall be reviewed. The Respondent shall cause Respondent's supervisor to meet with the Division and Board, either in person or telephonically, at Respondent's first meeting with the Board or have Respondent's supervisor speak with the Division's bureau manager, to discuss oversight issues and the responsibilities of a supervising physician. Respondent shall bring patient charts selected at random by Respondent's supervisor to the Division and Board whenever requested by the Division or Board. "General supervision" means that the supervisor (1) has authorized the work to be performed by the person being supervised; (2) is available for consultation with the person being supervised by personal face-to-face contact, or direct voice contact by telephone, radio, or some other means, without regard to whether the supervising licensee is located on the same premises as the person being supervised; and (3) can provide any necessary consultation within a reasonable amount of time and personal contact is routine.

For subsequent work with Ketamine for depression patients, the Respondent shall require primary care provider ("PCP") documentation, when available, from each patient, which shows that each patient is an appropriate candidate for Ketamine treatment (in addition to a screening evaluation which includes drug testing and questions on suicidal ideation, glaucoma, schizophrenia and other contraindicative conditions). Each treatment room will be monitored, at the very least, by video camera, and all Ketamine patients will be monitored by the Caretake devices at all times when they are in the Respondent's clinic for Ketamine for depression treatments (meaning these

patients are monitored just before injection of the Ketamine and at all times until they are properly discharged from the Respondent's clinic). Lastly, set discharge policies and procedures (including discharge paperwork for each patient), will be in place and will be implemented by the Respondent's clinic for each Ketamine patient. The Board and Division will review these discharge policies and possibly require more patient safeguards to be put in place by the Respondent during the probationary period.

g. If Respondent is self-employed in private practice, Respondent shall hire a supervisor, pre-approved by the Board and Division.

h. Respondent shall cause Respondent's supervisor to submit reports to the Board and Division assessing Respondent's compliance with the terms of Respondent's probation and ethics. The reports shall be submitted monthly for the first six months and quarterly thereafter, or at such frequency as directed by the Board and Division. The receipt of an unfavorable report may be considered to be a violation of probation.

i. In the event Respondent does not practice for a period of sixty (60) days or longer, Respondent shall notify the Division and Board in writing of the date Respondent ceased practicing. The period of time in which Respondent does not practice shall not be counted toward the time period of this Stipulation. It shall be within the discretion of the Division and Board to modify this requirement if Respondent satisfactorily explains to the Division and Board that compliance in Respondent's case was impractical or unduly burdensome. Respondent must work at least sixteen (16) hours per week and no more than forty-eight (48) hours per week to be considered "practicing" in Respondent's profession.

j. Respondent shall notify the Division and Board in writing within one (1) week of any change of employer, employment status, or practice status. This notification is required regardless of whether Respondent is employed in Respondent's profession.

k. If Respondent leaves the State of Utah for a period longer than sixty (60) days, Respondent shall notify the Division and Board in writing of the dates of Respondent's departure and return. The licensing authorities of the jurisdiction to which Respondent moves shall be notified by Respondent in writing of the provisions of this Stipulation. Periods of residency or practice outside the State of Utah may apply to the reduction of the period this Stipulation is in

effect, if the new state of residency places equal or greater conditions upon the Respondent as those contained in this Stipulation.

l. If Respondent is arrested or charged with a criminal offense by any law enforcement agency, in any jurisdiction, inside or outside the State of Utah, for any reason, or should Respondent be admitted as a patient to any institution in this state or elsewhere for treatment regarding the abuse of or dependence on any chemical substance, or for treatment for any emotional or psychological disorder, Respondent agrees to cause the Division and Board to be notified immediately. If Respondent at any time during the period of this agreement is convicted of a criminal offense of any kind, including an offense based on the conduct described in this Stipulation, or enters a plea in abeyance to a criminal offense of any kind, including a pending criminal charge, the Division may take appropriate action against Respondent, including imposing appropriate sanctions, after notice and opportunity for hearing. Such sanctions may include revocation or suspension of Respondent's license, or other appropriate sanctions.

m. Respondent shall maintain active licenses at all times during the period of this agreement.

n. Respondent shall immediately notify the Division in writing of any change in Respondent's residential or business address.

o. Respondent shall submit reports on the date they are due and shall appear at scheduled meetings with the Division and Board promptly. Failure to do so shall be considered a violation of this Stipulation.

p. Respondent shall submit a practice plan to the Division and Board within 90 days of the effective date of this Stipulation. The practice plan shall be submitted in a format prescribed by the Division and Board. The practice plan shall address Respondent's proper use and supervision of unlicensed medical assistants.

q. Any continuing medical education Respondent completes during the period of probation shall be pre-approved by the Division and Board.

r. **Fine**. Respondent shall pay a fine of $2500.00 (two thousand five hundred dollars), pursuant to Utah Code Ann. § 58-67-503, to the Division, within 90 days of the effective date of this Stipulation.

9. Upon approval by the Director of the Division, this Stipulation shall be the final compromise and settlement of this non-criminal administrative matter. Respondent acknowledges that the Director is not required to accept the terms of this Stipulation, and that if the Director does not do so, this Stipulation and the representations contained therein shall be null and void, except that the Division and the Respondent waive any claim of bias or prejudgment they might otherwise have with regard to the Director by virtue of his having reviewed this Stipulation, and this waiver shall survive such nullification.

10. Respondent shall abide by and comply with all applicable federal and state laws, regulations, rules and orders related to the Respondent's licensed practice. If the Division files a Petition alleging that Respondent has engaged in new misconduct or files an Order to Show Cause Petition alleging that Respondent has violated any of the terms and conditions contained in this Stipulation, the period of Respondent's probation shall be tolled during the period that the Petition or Order to Show Cause Petition has been filed and is unresolved.

11. This document constitutes the entire agreement between the parties and supersedes and cancels any and all prior negotiations, representations, understandings or agreements between the parties regarding the subject of this Stipulation. There are no verbal agreements that modify, interpret, construe or affect this Stipulation. The Respondent agrees not to take any action or make any public statement, that creates, or tends to create, the impression that any of the matters set forth in this Stipulation are without factual basis. A public statement includes statements to one or more Board members during a meeting of the Board. Any such action or

statement shall be considered a violation of this Stipulation.

12. The accompanying Order becomes effective immediately upon the approval of this Stipulation and signing of the Order by the Division Director. Respondent shall comply with all the terms and conditions of this Stipulation immediately following the Division Director's signing of the Order page of this Stipulation. The Respondent shall comply with and timely complete all the terms and conditions of probation. If a time period for completion of a term or condition is not specifically set forth in the Stipulation, Respondent agrees that the time period for completion of that term or condition shall be set by the Board or Division. Failure to comply with and timely complete a term or condition shall constitute a violation of the Stipulation and may subject Respondent to revocation or other sanctions. If the Respondent violates any term or condition of this Stipulation, the Division may take action against Respondent, including imposing appropriate sanction, in the manner provided by law. Such sanction may include revocation or suspension of Respondent's license, or other appropriate sanction.

13. The Respondent understands that the disciplinary action taken by the Division in this Stipulation may adversely affect any license that Respondent may possess in another state or any application for licensure Respondent may submit in another state.

14. The Respondent has read each and every paragraph contained in this Stipulation. He understands each and every paragraph contained in this Stipulation, and he has no questions about any paragraph or provision contained in this Stipulation.

DIVISION OF OCCUPATIONAL &
PROFESSIONAL LICENSING

BY: Larry Marx
LARRY MARX
Bureau Manager

DATE: 8/31/2020

RESPONDENT

BY: Robert Charles Hiemstra
ROBERT CHARLES HIEMSTRA

DATE: 8-28-2020

SEAN D. REYES
UTAH ATTORNEY GENERAL

APPROVED AS TO FORM:

BY: Dan Lau
Dan Lau
Counsel for the Division

DATE: 8/28/2020

BY: Greg Soderberg
Gregory Soderberg
Respondent's Attorney

DATE: 8/28/2020

ORDER

THE ABOVE STIPULATION, in the matter of **ROBERT CHARLES HIEMSTRA,** is hereby approved by the Division of Occupational and Professional Licensing, and constitutes my Findings of Fact and Conclusions of Law in this matter. The issuance of this Order is disciplinary action pursuant to Utah Administrative Code R156-1-102(7) and Utah Code Ann. § 58-1-401(2). The terms and conditions of the Stipulation are incorporated herein and constitute my final Order in this case.

DATED this _____ day of 08/31/2020, 2020.

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

Mark Steinagel (Aug 31, 2020 09:02 MDT)

MARK B. STEINAGEL
Director

Investigator: James Furner

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
Heber M. Wells Building
160 East 300 South
P O Box 146741
Salt Lake City UT 84114-6741
Telephone: (801) 530-6628

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING OF THE DEPARTMENT OF COMMERCE OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSES OF ROBERT CHARLES HIEMSTRA, MD UTAH LICENSES #333085-1205 & 333085-8905 TO PRACTICE AS A PHYSICIAN AND SURGEON AND TO PRESCRIBE AND ADMINISTER CONTROLLED SUBSTANCES IN THE STATE OF UTAH	**NOTICE OF AGENCY ACTION** Case No. DOPL-2019-477

THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING TO Robert Charles Hiemstra, MD ("Respondent"):

The Division of Occupational and Professional Licensing ("the Division") hereby files this notice of agency action. Said action is based on the Division's verified petition, a copy of which is attached hereto and incorporated herein by reference.

The adjudicative proceeding designated herein is to be conducted on a formal basis. It is maintained under the jurisdiction and authority of the Division as set forth in §58-1-401(2). **Within thirty (30) days of the mailing date of this notice, you are required to file a written response with this Division.** The response you file may be helpful to clarify, refine or narrow the facts and violations alleged in the verified petition.

Your written response, and any future pleadings or filings, which are a part of the official file in this proceeding, should be mailed or hand delivered to the following:

Signed originals to:	**A copy to:**
Division of Occupational and Professional Licensing Attn: Disciplinary Files **(by mail):** PO Box 146741 Salt Lake City UT 84114-6741	Dan Lau Assistant Attorney General Heber M. Wells Building **(by mail):** PO Box 140872 Salt Lake City UT 84114-0872

(by hand delivery):
160 East 300 South, 4th floor
Salt Lake City, Utah

(by hand delivery):
160 East 300 South, 5th floor
Salt Lake City, Utah

You may represent yourself or, at your own expense, be represented by legal counsel at all times while this action is pending. **Your legal counsel shall file an entry of appearance with the Division after being retained to represent you in this proceeding.** Until that entry of appearance is filed, the Division, its counsel, and the presiding officer will communicate directly with you.

The presiding officer for the purpose of conducting this proceeding will be Bruce L. Dibb, Administrative Law Judge, Department of Commerce, who will preside over any evidentiary issues and matters of law or procedure. If you or your attorney may have questions as to the procedures relative to the case, Judge Dibb can be contacted in writing at P O Box 146701, Salt Lake City, UT 84114-6701; by telephone at (801) 530-6706; or by electronic mail at bdibb@utah.gov.

Pursuant to a determination previously made by the Division which generally governs proceedings of this nature, the Division is providing the relevant and nonprivileged contents of its investigative file to you, concurrent with the issuance of this notice.

The Division is also providing its witness and exhibit list to you, concurrent with the issuance of this notice. The witness list identifies each individual the Division expects to present as a witness and includes a brief summary of their testimony at the hearing. The exhibit list identifies each anticipated document which the Division expects to present at the hearing. The Division is also providing a copy of any document to you that has not been otherwise made available to you through the investigative file.

Concurrent with your filing of a written response, you should provide to the Division a copy of any documents you have which relate to this case. Further, you should provide your witness and exhibit list to the Division. The witness list should identify each individual you expect to present as a witness and include a brief summary of their anticipated testimony. The exhibit list should identify each document you expect to present at the hearing.

If you fail to file a response within the 30 days allowed or

fail to attend or participate in any scheduled hearing, Judge Dibb may enter a default against you without any further notice to you.

After the issuance of a default order, Judge Dibb will cancel any prehearing conference or hearing scheduled in the Division's verified petition, conduct any further proceedings necessary to complete the adjudicative proceeding without your participation and determine all issues in the proceeding.

If you are held in default, the maximum administrative sanction consistent with the verified petition may be imposed against you. That sanction in this case is revocation of license [and an administrative fine.]

Counsel for the Division in this proceeding is Dan Lau, Assistant Attorney General, State of Utah. Mr. Lau may be contacted in writing at P.O. Box 140872, Salt Lake City, UT 84114-0872 or by telephone at (801) 366-0310. **You may, subject to the deadlines established herein, attempt to negotiate a settlement of this proceeding by contacting counsel for the Division.**

Any stipulation in lieu of a response should be jointly signed by yourself and the Division and filed within the time that a response would otherwise be due. Alternatively, any stipulation to resolve this case in lieu of the hearing shall be jointly signed by the parties and filed no later than one (1) week prior to the scheduled hearing.

Unless this case is resolved by a stipulation between the parties in lieu of the filing of a response, **a prehearing conference will be conducted as follows:**

January 2, 2020 at 9:30 A.M. by teleconference

During the conference, Judge Dibb will address and resolve any further discovery issues. A schedule for the filing of any prehearing motions shall also be established.

Subject to the Department of Commerce Administrative Procedures Act Rules which govern this proceeding, this formal adjudicative proceeding must be completed within 180 calendar days from the date of issuance of this notice of agency action.

You are entitled by law to an evidentiary hearing to determine whether your license to practice as a physician and surgeon and to prescribe and administer controlled substances in

the State of Utah should be revoked, suspended or subjected to other disciplinary action. Unless otherwise specified by the Director of the Division, the Physicians Licensing Board will serve as fact finder in the hearing. **The hearing will be conducted as follows:**

April 16, 2020 at 9:00 A.M., Room To Be Determined | 403 4th Fl
Heber M. Wells Building
4th floor
160 East 300 South
Salt Lake City, Utah

During the evidentiary hearing, you will have the opportunity to present an opening statement, submit evidence, conduct cross-examination, submit rebuttal evidence and offer a closing statement to the fact finder. After the close of the hearing, the Board will take the matter under advisement and then submit its Findings of Fact, Conclusions of Law and a Recommended Order to the Division for its review and action.

"A copy of Utah Admin. Code R477-101, Administrative Law Judge Conduct Committee, is available online at https://rules.utah.gov/publicat/code/r477/r477-101.htm."

Dated this 14 day of November, 2019.

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

By: _____
DEBORAH BLACKBURN
Presiding Officer for Issuance of Notice of Agency Action

DEPARTMENT OF COMMERCE
THE GREAT SEAL OF THE STATE OF UTAH
1896
OCCUPATIONAL AND PROFESSIONAL LICENSING

Dan Lau (USB No. 8233)
Assistant Attorney General
SEAN REYES (USB No. 7969)
Utah Attorney General
Commercial Enforcement Division
160 East 300 South, 5th Floor
Box 140872
Salt Lake City, UT 84114-6741
Telephone: (801) 366-0310
Email: dlau@agutah.gov

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING OF THE DEPARTMENT OF COMMERCE OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSES OF ROBERT CHARLES HIEMSTRA, M.D., TO PRACTICE AS A PHYSICIAN AND SURGEON AND TO PRESCRIBE AND ADMINISTER CONTROLLED SUBSTANCES IN THE STATE OF UTAH	)	**PETITION** CASE NO. DOPL 2019-- 477

PRELIMINARY STATEMENT

These claims were investigated by the Utah Division of Occupational and Professional Licensing (the Division) upon complaints that Robert Hiemstra (Respondent), a licensee of the Division, has engaged in acts and practices which constitute violations of the Division of Occupational and Professional Licensing Act, Utah Code Ann. §§ 58-1-101 to 58-1-601 (1993, as amended) and the Utah Medical Practice Act, Utah Code Ann. §§ 58-67-101 to 58-67-807 (2012).

The allegations against the Respondent in this Petition are based upon information and belief arising out of the Division's investigation. Each count in this Petition shall be deemed to incorporate by reference the allegations set forth in the other paragraphs of the Petition.

PARTIES

1. The Division is a division of the Department of Commerce of the State of Utah as established by Utah Code Ann. § 13-1-2 (2010).

2. At all times material to the allegations contained herein, the Respondent was licensed by the Division to practice as a physician and surgeon under the Utah Medical Practice Act, Utah Code Ann. §§ 58-67-101 to 58-67-807 (2012).

STATEMENT OF ALLEGATIONS

3. The Respondent was originally licensed to practice as a physician and surgeon, license number 333085-1205, and to prescribe and administer controlled substances, license number 333085-8905, in the State of Utah on or about May 27, 1997.

Allegations dealing with patient CH.

4. Patient CH, who suffers from a depressive disorder, contacted the Respondent's clinic on May 22, 2018 and spoke with the Respondent on the telephone. CH had suffered from serious depression since 1984, and she was surprised that her initial phone call with the Respondent was so informal and that the Respondent did not require detailed medical information from her. Ms. H offered to bring in her medical records to the Respondent so he could review them. The Respondent told CH that would not be necessary, and that there was no need for an evaluation. CH had previously inquired about Ketamine treatment for her depression at the University of

Utah (U of U), and the U of U psychiatrist was very thorough in the introductory interview, asking CH medical questions for over an hour. Ms. H scheduled her appointment with the Respondent for Friday, May 25th, and the Respondent advised CH to stop food and water at noon that day.

5. When CH arrived at the Respondent's clinic, one of the Respondent's assistants weighed her and took her blood pressure, her heart rate and her oxygen level. The Respondent brought CH back to his office with Amanda, an intern who was studying to be a nurse. CH offered her medical records to the Respondent and briefly went over her mental health history with him. The Respondent again told CH that her medical records were not necessary to proceed with treatment. The Respondent asked CH what medications she was taking, typing them into his laptop computer. The Respondent also looked up medical interactions with Ketamine and the drugs CH was taking on his cell phone. The Respondent informed CH that one of her medications could interact with Ketamine, but that it would only be increased nausea and dizziness.

6. The Respondent asked CH if she had any allergies, and that (along with the questions on current medications, and the taking of CH's blood pressure, heart rate and oxygen level) was the extent of his medical evaluation of CH. The Respondent discussed the administration method of the Ketamine, and that he preferred injection rather than an infusion because of the increased risk of air emboli with an IV. Dr. Hiemstra stated that there were no potential risks or side effects, outside of nausea, from the Ketamine itself. The Respondent did not have CH sign any informed consent or waiver documents prior to administering Ketamine to her.

7. The Respondent moved CH to an adjoining office and placed her in a chair that looked out a window. Another blood pressure reading was taken, which showed a slightly elevated number for CH from the initial blood pressure reading. Dr. Hiemstra informed CH that this particular blood pressure machine was reading a little higher than the other monitoring device.

8. CH was speaking briefly with Amanda, the Respondent's intern, when the Respondent came back with a prefilled syringe and injected the Ketamine into CH's right arm. The Respondent told CH that she would be feeling the effects of the Ketamine in four to five minutes, and that he would return in 30 minutes to further assess her. Dr. Hiemstra placed a large timer in the room and left CH alone with a blood pressure cuff on her left arm and no means to ring for help if she was in any kind of distress. CH had no ill effects from the first Ketamine injection and felt great afterwards.

9. Approximately 40 minutes after the first injection, the Respondent returned to the room that CH was in and apologized for the delay in his return. The Respondent asked CH how she was feeling, and she informed him with a thumbs up that she was feeling good. Dr. Hiemstra asked CH if she wanted another injection. CH replied that she did not know as she was feeling good, but that she would trust his judgment. The Respondent replied by saying, "Carrie, you know what you want." The Respondent left the room and returned with another prefilled syringe of Ketamine. Hiemstra injected the Ketamine into CH's right arm and left the room again. CH was again left in the room alone with no one to monitor her medical status. CH believed it was the Respondent's normal practice to give Ketamine patients two shots. When CH was administered

the Ketamine on May 25, 2018, there were no crash carts or resuscitative devices in the Respondent's clinic.

10. Within minutes of the second injection, CH started hallucinating and yelling for help. One of the Respondent's assistants tried to console CH by telling her that she had a similar reaction and things would be ok. Ms. H felt her brain was so damaged that she would be permanently impaired and much worse off than before she received the two Ketamine injections. CH thought her teeth were missing or shattered. She repeatedly chastised herself for coming to the Respondent's clinic, and she believed that she would either die or need to be institutionalized due to the brain damage she had suffered. CH demanded emergency medical care, and at some point the Respondent injected her with a syringe of Ativan. This was the most terrifying experience CH had ever had in her life. The Respondent and his assistants refused to call for emergency medical assistance. CH noted her hallucinations were subsiding and started yelling at the office assistant to get her friend.

11. CH complained of a need to vomit, and the Respondent placed a garbage can in front of her and told her to use it. There was no biohazard liner in the garbage can. About this time, CH was sitting on a couch when her friend, BH, entered the Respondent's clinic.

12. CH had called BH twice on the night of her treatment. During the first call, Ms. H sounded cheerful and fine. During the second call, CH sounded frightened and confused. When BH arrived and was able to get into the Respondent's clinic, he saw CH on a couch with the Respondent holding a syringe opposite her. Ms. H was telling the Respondent that he should not have given her the second injection. The Respondent was telling CH that this was a normal

reaction. BH wanted to get CH out of the facility, so he ushered her out of the clinic before she had paid the Respondent. BH was surprised by the change he noticed in CH between the first call and the second call, and when he saw CH in the clinic and on the couch.

Within ten minutes of BH entering the Respondent's clinic, BH left with CH. The Respondent did not give CH any exit or discharge paperwork, and the Respondent did not give BH any instructions on how to care for CH after the Ketamine injections. The Respondent's medical notes for May 25, 2018 for CH state, "When observed to be sufficiently stable, the patient was released to her husband for transportation home." BH was not CH's husband, and he noted that CH was extremely agitated and upset. CH asked the Respondent, "What did you do to me?" BH noted that CH was not physically stable, and he helped guide her back to BH's car because she would have otherwise fallen walking to the vehicle. BH drove CH home and stayed with her for 90 minutes because he wanted to make sure she was ok. Ms. H was crying in the Respondent's clinic, and BH was scared for her. BH noted that the Respondent was getting defensive because CH was so upset and agitated about the Ketamine injections.

Allegations dealing with patient BM.

13. On or about August 13, 2017, patient BM reported to the Respondent's clinic for Ketamine treatment for a major depressive disorder. She was accompanied by a friend, MW. After receiving one Ketamine treatment, BM searched the Respondent's clinic for a provider to clear her to drive home. No staff was in the clinic to clear BM, so she was able to leave the facility without any medical evaluation whatsoever. Prior to receiving this Ketamine dosage, BM was not medically evaluated or assessed by the Respondent or anyone on his staff.

14. On or about August 15, 2018, BM reported to the Respondent's clinic for her second Ketamine injection. She was accompanied by a friend, TN. Prior to receiving this second Ketamine dosage, BM was not medically evaluated or assessed by the Respondent or anyone on his staff. Prior to giving BM her first Ketamine injection, the Respondent's staff took BM's blood pressure. Two feet away from BM a male patient was getting a Ketamine injection. The Respondent's staff told this male patient to stay in his chair because he had fallen the last time he had got up after a Ketamine shot. This male patient got up anyway and went to the bathroom. The Respondent gave BM her first injection in her butt. BM told TN that she was "so scared" and that TN needed to calm her down. BM and TN were left alone with no panic button or way of contacting the Respondent's staff. Thirty minutes after the first shot, BM received a second shot. She was again nervous.

Thirty minutes after the second Ketamine shot, BM and TN could not find someone on staff to properly check them out of the clinic. BM told TN that this is what happened the first time she received Ketamine from the Respondent. There was no crash cart in the Respondent's facility at the time, and no vital sign measurements were taken with BM. BM had not been hooked up to any measuring devices during the administration of the Ketamine, and BM appeared, to TN, to be "in a fog." Three dogs were in the clinic at the time, and one of the dogs climbed on BM, who did not want the animal to be jumping on her. BM scheduled a third appointment with the office manager. When she did this, she was not asked any medical questions from either the Respondent or any of the Respondent's associates/assistants. The

Respondent's medical notes for August 15, 2018 for BM state, "when observed to be sufficiently stable, the patient was released to their transportation home."

15. When BM arrived for her third Ketamine treatment on August 17, 2018 (accompanied by her friend, TN), she passed the Respondent in the main common area of the clinic speaking with a distraught young girl and her mother (and offering this patient no privacy). The young patient was describing how terrible the treatment felt. The Respondent and a nurse practitioner/assistant were repeating the same things (medical terminology associated with this young patient's treatment) to this patient and her mother, which appeared to be causing this young patient more anxiety. While this was occurring, the Respondent's staff was not attending to BM.

16. Because of the delay, BM's friend asked the Respondent if BM's treatment was going to start. The Respondent came into the treatment room where BM was located and yelled, "We have other patients. Is there a problem?" BM expressed her concerns, and the Respondent became very angry, telling her that she was out of line. The Respondent's nurse practitioner and/or assistant came into the room and attempted to calm the situation by saying that they "weren't hearing each other."

17. BM was upset and afraid to receive treatment in such an upset state of mind, so she left the clinic. After leaving, BM called the Respondent's clinic and asked to continue treatment with the nurse practitioner/assistant. When the Respondent's clinic did not confirm a follow up appointment with the nurse practitioner, BM asked for a refund of the fees she had paid the Respondent. The Respondent texted BM, stating that he would refund her fees. There were subsequent communications between the Respondent's office and BM.

Allegations dealing with patient DN.

18. On or about August 14, 2018, patient DN reported to the Respondent's clinic for Ketamine treatment for anxiety and depression. The Respondent's office had told DN not to eat four hours before the treatment. DN called the Respondent's office an hour before the treatment and informed the Respondent that he had eaten an apple three hours before the scheduled appointment. The Respondent informed DN that he "should be fine" and encouraged DN to keep the appointment. DN did not give the Respondent any medical records prior to receiving the Ketamine from Dr. Hiemstra. The Respondent asked DN, "Why are you here?" There were no follow up questions. The Respondent left DN waiting twice for treatment for over 20 minutes while Dr. Hiemstra was distracted by other tasks and telling stories to people about his dog chasing ducks. When DN tracked the Respondent down to administer the Ketamine, Dr. Hiemstra was a little annoyed. The Respondent then took DN into a "treatment room," where there was a syringe full of Ketamine intended for another patient. Dr. Hiemstra quickly picked up the syringe and put it away. The Respondent then gave DN a waiver that was signed and filled out by another patient. Hiemstra did not give DN a new waiver to fill out or sign before the medical treatment.

After receiving the Ketamine dosage from the Respondent, DN became very nauseated and vomited the food he had eaten before the appointment. One of the Respondent's employees came to DN with a syringe and asked him if he wanted something for the nausea. DN, not knowing this employee or her medical qualifications, declined the offer.

After the appointment, DN wrote a Google Review of his experience with the Respondent's clinic, and the Respondent wrote a response to DN's review. This response described DN's mental health condition and stated what the Respondent thought would happen to DN if he did not get treatment (insinuating that DN's mental illness might kill him). The Respondent made the following statements in his online Google response: "Mr. Nibley's nausea was fairly impressive as nausea goes." "But Mr. Nibley's nausea was different; it might kill him. Not, of course, the nausea per se, but if that nausea played a role in directing Mr. Nibley away from the Ketamine that might well cure his depression, that depression might be freed to take his life. At the very least, his depression-ridden life without that Ketamine would be a medical weight that would lead to a much less happy and gratifying existence. In short, that nausea was very dangerous to Mr. Nibley." Dr. Hiemstra went on to state in this internet response, "I felt that the wisest medical course was to demonstrate less sympathy to the nausea, and to exercise a bit more of the soldier's hostility toward an enemy. Afterall, that nausea was arguably at the moment Mr. Nibley's greatest enemy. I still hold that point of view. In fact, I would [add] to that view that an even healthier attitude would encourage one to haughtily vomit facing into the wind and then laughing at the vomitus spattered on your cheeks."

The Respondent closed his internet response by saying, "He should also consider adhering to the directives of our Ketamine consent form which suggests no food in the four hours prior to treatment. If Mr. Nibley follows these directives, the chances of his enjoying a much happier and productive life than he is currently directed toward are greatly enhanced." The Respondent's internet response did not mention that DN had called Dr. Hiemstra before the

appointment to reschedule because he had eaten an apple three hours before the appointment, but the Respondent had told DN, "you should be fine" and encouraged him to keep the appointment.

DN was extremely upset that the Respondent had discussed his mental illness on a pubic forum. He felt the Respondent had minimized his mental health issues, and that the Respondent's comments in a public online forum made him feel even more isolated and depressed. DN's online review of the Respondent stated, "If you go to this clinic, do your research beforehand. Don't expect them to explain what you should expect from the experience. Ask a lot of questions and if you are worried about getting sick, insist on a small dose to start. Also have someone come and sit with you. They are not really equipped to help you through the experience or process anything after the experience."

Allegations dealing with the Respondent leaving a Ketamine patient alone in a medical office with an IV needle in her arm in Kaysville in March 2017.

19. On or about March 6, 2017, at approximately 7:30 p.m., the Respondent, while working for/with Dr. Christian Obah in Kaysville, Utah at the Lifespring Pain Management Clinic, was administering Ketamine to a patient suffering from depression. The Respondent was administering the Ketamine to patient KB via intravenous infusion. Dr. Hiemstra left KB alone in the infusion room with the IV needle still in her arm and then proceeded to leave Dr. Obah's medical clinic. KB was left alone in the infusion room, and she called out for the Respondent. When she got no response from the Respondent, KB became extremely worried and texted her brother. Her brother informed her that everyone had left the medical office. KB eventually pulled the IV out of her arm. She was distraught that she had been left alone in the clinic, but

she did not want to leave the premises until an employee responded because she did not want to be blamed for taking anything.

Kaysville P.D. was dispatched to the scene at approximately 8:20 p.m., and Officer Rich called the Respondent after meeting KB and finding a sticky note with "Dr. H" and a contact phone number written on it. The Respondent told Officer Rich that he "completely forgot" about KB and would report to the clinic. Dr. Obah also returned to the clinic, and he was concerned that KB had air pumped into her vein when she removed the IV. When the Respondent arrived at the clinic, he told Dr. Obah and KB that air could not have gotten into KB's veins because she had removed her IV before. KB was immediately defensive of this comment and became emotional, stating she felt like the Respondent was saying this situation was her fault. Dr. Obah told KB that his clinic would "make things right." Dr. Hiemstra and KB got into a heated verbal argument in the clinic parking lot over the issue of fault, and Officer Rich told the Respondent that he needed to leave. Officer Rich walked with the Respondent to his car until he left the premises. Dr. Obah quit scheduling cases with the Respondent because he wanted to review protocols so there was not a repeat of the incident with KB at his clinic.

Allegations dealing with patient PR.

20. The Respondent has been treating patient PR for chronic anxiety and depression since at least August of 2018. In August of 2018, the Respondent administered increasing doses of Ketamine to PR. On August 6, 2018, Dr. Hiemstra gave PR, who weighed 204 pounds at the time, 185 mg of Ketamine via four intramuscular injections (30 mg, 45 mg, 50 mg and 60 mg). The Respondent's medical notes for PR's treatment session on August 6, 2018 stated that the

"desired" Ketamine dose was 47 mg. This statement from the Respondent is based on the majority of medical literature showing that the appropriate Ketamine dosage for depression is a dose of 0.5 mg per kilogram of a patient's weight. In PR's case, the Respondent's comments tracked with the literature since PR's weight was approximately 94 kg. This medical literature also shows that patients do not get any increased benefits from a dosage higher than 0.5 mg per kg of patient weight. Hiemstra's August 6th notes also stated that "PR is very tolerant of Ketamine and wanted more."

Between August 6, 2018 and April 12, 2019, the Respondent administered more than 47 mg to PR on at least 33 occasions, with the vast majority (27) of these 33 occasions being dosages that were at least ten times the recommended 47 mg dosage for PR. On 21 occasions over this same time period, PR received over 20 times the recommended 47 mg dosage of Ketamine (a minimum of 940 mg Ketamine). Thirty two of these 33 dosages previously mentioned were a minimum of 2 mg/kg of PR's body weight (a minimum of 188 kg of Ketamine). Anesthetic dosages are typically 1.5 to 2 mg/kg of Ketamine.

On August 8, 2018, the Ketamine dosage was increased to 210 mg. The Respondent also gave PR 1 mg of Ativan and 12.5 mg of Phenergan. Dr. Hiemstra's August 8th subjective notes for PR stated that "Everything's better and PR wants a lot more."

On August 10, 2018, the Respondent increased PR's Ketamine dosage to 280 mg. This dosage was given to PR in three divided doses 30 minutes apart. On August 12, 2018, the Ketamine dosage was increased to 412 mg. This dosage was given in three divided doses of 12mg, 200 mg and 200 mg 30 minutes apart. The Respondent's August 12th subjective notes for

PR stated that "anxiety and depression are better but pain little affected after the treatment." On August 14, 2018, the Ketamine dosage was increased to 720 mg. This dosage was given in four divided doses of 120 mg, 150 mg, 250 mg and 200 mg 30 minutes apart. Dr. Hiemstra's August 14th subjective notes for PR stated that "she takes huge doses and is getting much positive from them, but the pain is only mildly affected." On August 18, 2018, the Ketamine dosage was increased to 900 mg. This dosage was given in three divided doses of 300 mg 30 minutes apart. The Respondent's medical notes for this day noted that PR "got a little groggy but holds her Ketamine extremely well." The Respondent's subjective notes for August 18th stated that "PR takes huge amounts of Ketamine without feeling much effect."

On or about September 26, 2018, the Ketamine dosage was increased to 1600 mg. On November 3, 2018, the Respondent's medical notes for PR noted that he "remained concerned about PR's Ketamine influenced trips to the bathroom which are always, of course, dangerous enterprises. Paige does not always take the walker to the restroom." In Hiemstra's medical notes on PR from November 17, 2018, the Respondent stated that "PR was given her usual Olympian dosage regimen of 1600 mg divided into four 400 mg intramuscular injections given 30 minutes apart. She did well with the only concerning part of her treatment being her trip to the bathroom which is often a seemingly dangerous affair." On December 14, 2018, the Respondent's medical notes for this day noted that PR "was given her usual megadose of four 400 mg intramuscular Ketamine's 30 minute apart and did well." The Respondent also noted that PR "got up a little bit early once and nearly fell."

On December 21, 2018, Dr. Hiemstra indicated in his medical records for PR that "despite requests for the 100 mg per ML vials, she was again given the 50's. This results in way more fluid than is necessary, so I gave her the 'Portuguese Ketamine' from my stock." The Respondent's subjective notes for PR on December 21, 2018 also stated, "Her general disease continues to progress and Paige would like another increasing dosage. If only she had good veins." On January 22, 2019, the Respondent gave PR 2000 mg of Ketamine in five 400 mg intramuscular injections. The Respondent's medical notes for this date indicated that PR had "no roaming incidents for the treatment session."

On February 4, 2019, Hiemstra's medical notes for this treatment date (where she was given 2000 mg of Ketamine) indicated that PR "got up to go to the bathroom alone and fell." On March 4, 2019, the Respondent's medical notes for PR noted that PR, after being given 2000 mg of Ketamine, was having a "harder time with orientation and ambulation." The Respondent also noted on this date that the time periods between Ketamine injections for PR were lengthened because of the patient's problems with orientation and moving/walking. His notes indicated that PR "doesn't recover as she did before" and that the intervals between Ketamine injections were made as long as 90 minutes. In addition to the Ketamine the Respondent was giving PR, the patient was also taking a 100 mg tablet of Topamax and a 225 mg tablet of Venlafaxine. The Respondent's March 4th medical notes also noted that "we will cut back on her milligrams dosage." On April 12, 2019, PR was given 1800 mg of Ketamine in six 300 mg intramuscular injections spread out over a period of time. Hiemstra's subjective notes for this date state,

"Paige's general health is apparently deteriorating secondary to her *undefined chronic disease*." (Emphasis added.)

In all of PR's medical records detailing her Ketamine treatment from August 2018 through April of 2019, there is no evidence of continuous cardiopulmonary monitoring of PR even though the Respondent was giving PR up to 2000 mg of Ketamine.

A concerned member of the Respondent's staff believed that PR was being given "crazy" amounts of Ketamine and was concerned about PR's well-being. This staff member noted that PR was completely incapacitated by the administration of approximately 400 mg of Ketamine at the start of PR's Ketamine treatments with the Respondent. This staff member voiced her opinion to the Respondent that he was using too much Ketamine with PR, and that PR was falling when she tried to go to the restroom.

Allegations dealing with Patient KC.

21. Patient KC had received four Ketamine treatment sessions from the Respondent on April 4 and 22, 2019; June 29, 2019, and July 16, 2019. On September 6, 2019, KC reported to Dr. Hiemstra's clinic for her fifth treatment session. KC informed the Respondent's assistant that she had a bad reaction from the July 16th injections (100 mg and 110 mg), and that she had been angry, disoriented and did not feel well for several days after receiving this total dosage of 210 mg of Ketamine. KC further informed the assistant that she had a headache since the July 16th injections, and that she was concerned that the higher dosage was interacting with some of her other medications. The Respondent's assistant did not immediately get the Respondent, even after hearing KC's concerns. The Respondent's assistant tried to talk KC into taking a higher

dosage of Ketamine. KC had to be firm with the assistant to emphasize her point that she did not want a higher dosage. No blood pressure or oxygen level monitoring was brought into the treatment room even though it was onsite in the clinic. KC's partner, SM, was present during the entire treatment session. Within 10 minutes of receiving the first dose of 110 mg of Ketamine, KC's eyes flew open and started watering. Additionally, KC was drooling. KC also started panting and moaned twice. KC's skin was pale, cold and clammy. SM noted that KC was completely unresponsive verbally and physically, which was not KC's experience at previous treatment sessions.

SM worried about KC's health, ran out of the room, and got the Respondent's assistant. The assistant took KC's blood pressure and oxygen levels, and it was noted that KC's oxygen levels had started to drop into the 80's. The assistant left the room and said she was getting the doctor. When the assistant came back into the room (but before the Respondent responded), KC's oxygen levels had lowered to 77. When the Respondent entered the room, he had a conversation with SM and stated that KC might be "breath holding" or having a "scary experience." The assistant interrupted and informed the Respondent that KC's oxygen levels had dropped to 77. Dr. Hiemstra then told the assistant to get oxygen and put it on two liters. SM informed the Respondent that KC's oxygen levels were low for about 15 minutes while the levels were being monitored, but she was not sure if they were low before the levels were being monitored. KC's oxygen levels rose, and the assistant asked the Respondent if she should administer the second injection of Ketamine. The Respondent replied that they should let KC "come out of it" and then make that decision. SM stated that since KC was not coming out of it,

they should not administer the second injection and that KC was not in any shape to make a coherent medical decision on the second injection.

Dr. Hiemstra had a discussion with SM and tried to convince her to take KC to the ER. SM declined to do this because she was worried that KC's oxygen levels would bottom out while she was driving and because KC was not awake, coherent or moving much. The Respondent called the paramedics, and when they arrived, SM answered most of their questions on what type of clinic the Respondent was running. Hiemstra downplayed the incident with the paramedics, again saying there was "breath holding" and a "scary experience." The paramedics informed SM that they could either get KC into SM's car or take KC to the hospital. SM again declined to take KC in her car because KC was unable to sit or stand and could not say who she was. The paramedics informed SM that KC's oxygen levels at that time were 96. KC's one memory of the incident was that she could not breath. KC was transported to IHC Hospital in Murray, Utah. KC stayed at the hospital for three hours in order to become coherent and safely leave. She now suffers from memory issues, confusion and an inability to keep a train of thought. KC cries over random flashbacks of the whole ordeal at the Respondent's clinic on September 6, 2019.

The Respondent's medical notes for KC concerning the September 6, 2019 incident note that KC was taken by ambulance to the hospital, that KC's oxygen levels had dropped into the high 70's, and that there were short periods of "breath holding." Hiemstra's subjective notes for September 6, 2019 stated that KC was "Doing well in general."

APPLICABLE LAW/RULES

22. Subsections (a) and (b) of Utah Code Ann. § 58-1-401(2) (1996) give the Division the legal authority to "revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee" when "the licensee has engaged in unprofessional or unlawful conduct, as defined by statute or rule under this title[.]"

23. Utah Code Ann. § 58-1-501(2)(g) defines "unprofessional conduct" to include:

> ((g) practicing or attempting to practice an occupation or profession regulated Under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence[.])

24. Subsection (15) of Utah Admin Code R156-67-502 defines "unprofessional conduct" to include:

> (15) violation of any provision of the American Medical Association (AMA) "Code of Medical Ethics," 2012-2013 edition, which is hereby incorporated by reference.

25. Provision 5.059 of the AMA Code of Medical Ethics states, in part, that physicians "must seek to protect patient privacy in all of its forms, including 1) physical, . . . 2) informational, . . ., 3) decisional, . . ., and 4) associational. Such respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship."

26. Provision 9.045 of the AMA Code of Medical Ethics states that personal conduct, whether verbal or physical, that negatively affects or that may potentially negatively affect patient care constitutes disruptive behavior.

27. Provision 9.123 of the AMA Code of Medical Ethics states that derogatory language or actions on the part of physicians can cause psychological harm to those they target. Therefore, any such conduct is profoundly antithetical to the Principles of Medical Ethics.

28. Provision 8.08 of the AMA Code of Medical Ethics states that informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent. Provision 8.08 further states that physicians should sensitively and respectfully disclose all relevant medical information to patients.

29. Provision 10.01(3) (Fundamental Elements of the Patient-Physician Relationship) of the AMA Code of Medical Ethics states that the "patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs."

30. Provision 10.01(4) (Fundamental Elements of the Patient-Physician Relationship) of the AMA Code of Medical Ethics states that "the patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest."

31. Section I of the Preamble of the AMA Code of Medical Ethics states that a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section IV of the Preamble of the AMA Code of Medical Ethics states that a physician shall respect the law.

Utah Admin. Code R156-1-102(2) defines "aggravating circumstances" as any considerations or facts that may justify an increase in the severity of an action to be imposed upon an application or licensee. Subsections (c), (d) and (h) specifically list a pattern of misconduct, multiple offenses, and vulnerability of a victim as aggravating circumstances.

32. Section VIII of the Preamble of the AMA Code of Medical Ethics states that a physician shall, while caring for a patient, regard responsibility to the patient as paramount.

33. Utah Code Ann. § 58-1-501(2)(b) defines "unprofessional conduct" to include:

> (b) violating, or aiding or abetting any other person to violate, any generally accepted professional or ethical standard applicable to an occupation or profession regulated under this title[.]

COUNTS I-VIII:
UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE RESPONDENT'S TREATMENT OF PATIENT CH: A PATTERN OF INCOMPETENCY OR NEGLIGENCE AND A PATTERN OF VIOLATIONS OF THE AMA CODE OF MEDICAL ETHICS.

34. Paragraphs 1 through 33 are incorporated herein and by this reference made a part hereof.

35. As described in Paragraphs 4 through 12, the Respondent failed to provide patient CH with an informed consent form that included information on the side effects of Ketamine, the fact that this particular use of Ketamine for depression was an off label use and was not approved by the FDA at the time, the potential for complications with permission to provide the appropriate treatment and possibly engage the 911 system to transport the patients to an appropriate hospital, expectations during and after treatment, and the requirement to provide appropriate transportation back home by a person who is not impaired. The Respondent also failed to provide CH or her escort home, BH, with any exit or discharge paperwork that instructed either

CH or BH on potential side effects of the Ketamine, instructions on what to do to deal with any post-Ketamine problems or contact information in case there were problems. Dr. Hiemstra also failed to require (and in fact declined taking CH's medical history) a complete medical history and failed to perform a medical evaluation of CH prior to administering Ketamine to her. Additionally, there were no crash carts or resuscitative devices in the Respondent's clinic when he administered two doses of Ketamine to CH. Lastly, the Respondent encouraged CH to take a second injection of Ketamine after CH was apprehensive about a second injection and without having a clear and complete picture of CH's mental health history and prior medical records and care. This second injection led to a terrifying experience for CH, in which she believed her brain was permanently damaged and her teeth were missing or shattered. Therefore, Dr. Hiemstra has engaged in unprofessional conduct with CH on at least eight occasions pursuant to Utah Code Ann. § 58-1-501(2)(g) (a pattern of incompetency or negligence by failing to honor his duty to give CH informed consent on the Ketamine injections prior to starting the Ketamine treatment, by failing to require a medical history of CH prior to starting the treatment, by failing to medically evaluate CH prior to administering Ketamine to her, by failing to have a crash cart in his clinic when he was administering Ketamine to CH, and by encouraging a second Ketamine injection without having a complete picture of CH's medical history) and pursuant to Utah Admin. Code R156-67-502(15) and Utah Code Ann. § 58-1-501(2)(b) (violating provisions 8.08 of the AMA Code of Medical Ethics, and sections I and VIII of the Preamble of the AMA Code of Medical Ethics). The Respondent's unprofessional conduct gives the Division the legal authority to impose sanctions against the his professional licenses pursuant to Utah Code Ann. §

58-1-401(2)(a). Sadly, a number of aggravating circumstances apply in Dr. Hiemstra's treatment of CH which justify an increase in the severity of the disciplinary action taken against the Respondent' s professional licenses. There was a pattern of misconduct and multiple offenses in this case. Additionally, CH, who suffered from serious depression for a long period of time, was an especially vulnerable victim.

COUNTS IX-XVI:
UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE RESPONDENT'S TREATMENT OF PATIENT BM: A PATTERN OF INCOMPETENCY OR NEGLIGENCE AND A PATTERN OF VIOLATIONS OF THE AMA CODE OF MEDICAL ETHICS.

36. Paragraphs 1 through 33 are incorporated herein and by this reference made a part hereof.

37. As described in Paragraphs 13 through 17, the Respondent failed to require a complete medical history and failed to perform a medical evaluation of BM prior to administering Ketamine to her. The Respondent also failed to provide BM with documentation of her physical status and vital signs prior to discharge on August 13 and 15, 2018, and he failed to provide BM with adequate follow-up information on possible complications from the treatment and reasons for immediate or emergent reevaluation. Additionally, there were no crash carts or resuscitative devices in the Respondent's clinic when he administered Ketamine to BM.

In addition to these four examples of negligent medical conduct, Dr. Hiemstra also violated various provisions of the AMA Code of Ethics by not safeguarding patient privacy on August 15 and 17, 2018; and by yelling at BM and negatively affecting her on August 17, 2018 (to the point that she wanted a refund for her payments to the Respondent). Therefore, the

Respondent has engaged in unprofessional conduct with BM on at least eight occasions pursuant to Utah Code Ann. § 58-1-501(2)(b) and (g), Utah Admin. Code R156-67-502(15), and Provisions 5.059, 9.045, 9.123, 10.01(3), 10.01(4) of the AMA Code of Medical Ethics, and Sections I and VIII of the Preamble of the AMA Code of Medical Ethics. The Respondent's unprofessional conduct gives the Division the legal authority to impose sanctions against his professional licenses pursuant to Utah Code Ann. § 58-1-401(2)(b).

There are also a number of aggravating circumstances that apply in Dr. Hiemstra's treatment of BM which justify an increase in the severity of the disciplinary action taken against the Respondent' s professional licenses. There was a pattern of misconduct and multiple offenses in this case. Additionally, BM, who suffered from serious depression for a long period of time, was an especially vulnerable victim. It was especially troubling that the Respondent made the choice to yell at BM and upset her to the point that she decided to leave Hiemstra's clinic on August 17, 2018.

COUNTS XVII-XXVII:
UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE CARE OF PATIENT DN: A PATTERN OF INCOMPETENCY OR NEGLIGENCE AND A PATTERN OF VIOLATIONS OF THE AMA CODE OF MEDICAL ETHICS.

38. Paragraphs 1 through 32 are incorporated herein and by this reference made a part hereof.

39. As described in Paragraph 18, the Respondent encouraged DN to continue with his Ketamine treatment on August 14, 2018, even after DN had informed the Respondent that he had eaten something three hours prior to the scheduled treatment session (which contradicted the Respondent's earlier advice to DN that he should not eat anything up to four hours prior to the

Ketamine treatment). This poor decision on the Respondent's part led to DN experiencing nausea and vomiting at the Respondent's clinic. Further, Dr. Hiemstra failed to require a complete medical history and failed to perform a medical evaluation of DN prior to administering Ketamine to him; and he left a syringe full of Ketamine intended for another patient in the treatment room when DN was about to be treated. Additionally, the Respondent gave DN a waiver form that was filled out by another patient and failed to give DN a new waiver to fill out or sign before DN's Ketamine treatment.

In addition to these five examples of negligent medical conduct, the Respondent also egregiously violated six provisions of the AMA Code of Ethics by naming DN and commenting on his medical condition and mental health in an online Google Response. In this unprofessional and unethical Google Response, Hiemstra stated that DN's nausea might kill him because it might direct him away from the Ketamine that "might well cure his depression."

Therefore, the Respondent has engaged in unprofessional conduct with DN on at least eleven occasions pursuant to Utah Code Ann. § 58-1-501(2)(b) and (g), Utah Admin. Code R156-67-502(15), and Provisions 5.059, 9.045, 9.123, 10.01(3), 10.01(4) of the AMA Code of Medical Ethics, and Sections I and VIII of the Preamble of the AMA Code of Medical Ethics. The Respondent's unprofessional conduct gives the Division the legal authority to impose sanctions against his professional licenses pursuant to Utah Code Ann. § 58-1-401(2)(b).

Additionally, a number of aggravating circumstances apply in Dr. Hiemstra's treatment of DN which justify an increase in the severity of the disciplinary action taken against the Respondent' s professional licenses. There was a pattern of misconduct and multiple offenses in

this case. Further, DN, who suffered from serious depression for a long period of time, was an especially vulnerable victim. It was especially troubling that the Respondent would violate DN's right to the privacy of his medical treatment by posting an online Google Response that specifically stated that DN's nausea might kill him because it might direct him away from the Ketamine that "might well cure his depression." Dr. Hiemstra's cold and unprofessional comments in an open online forum made DN feel even more isolated and depressed.

COUNT XXVIII: UNPROFESSIONAL CONDUCT: UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE CARE OF PATIENT KB: GROSSLY NEGLIGENT CONDUCT.

40. Paragraphs 1 through 33 are incorporated herein and by this reference made a part hereof.

41. As described in Paragraph 19, on or about August 6, 2018, Dr. Hiemstra left patient KB alone in a Kaysville medical clinic with an IV of Ketamine still attached to her arm. The Respondent compounded his grossly negligent conduct with KB by returning to the clinic after the police had responded and further upsetting KB by making her feel that this incident was her fault. Officer Rich, the responding Kaysville, Utah police officer, told the Respondent he needed to leave and walked Hiemstra to his car because the Respondent was arguing with KB in the clinic parking lot. The Respondent's grossly negligent actions on August 6, 2018 constituted unprofessional conduct pursuant to Utah Code Ann. § 58-1-501(2)(g). Dr. Hiemstra's unprofessional conduct gives the Division the legal authority to impose sanctions against his professional licenses pursuant to Utah Code Ann. § 58-1-401(2)(b).

There are yet again a number of aggravating circumstances that apply in the Respondent's treatment of KB which justify an increase in the severity of the disciplinary action

taken against Hiemstra's professional licenses. There was a pattern of misconduct and multiple offenses in this case. The Respondent forgot about his patient and left her alone in a medical office, he left her alone with an IV of Ketamine in her arm, and he then proceeded to argue with her and upset her when he returned to the medical clinic after being called by a Kaysville, Utah police office. In fact, the responding police officer, Officer Rich, told the Respondent he needed to leave the premises and walked Hiemstra to his car because the Respondent was seriously upsetting KB. Lastly, KB, who suffered from depression and was left alone at night in a medical clinic, was an especially vulnerable victim.

COUNTS XXIX-LXII:
UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE CARE OF PATIENT PR: A PATTERN OF INCOMPETENCY OR NEGLIGENCE AND A PATTERN OF VIOLATIONS OF THE AMA CODE OF MEDICAL ETHICS.

42. Paragraphs 1 through 32 are incorporated herein and by this reference made a part hereof.

43. As described in Paragraph 20, between August 6, 2018 and April 12, 2019, the Respondent administered more than the recommended dosage of 47 mg of Ketamine to PR on at least 33 occasions. Further, on at least 32 occasions during the same time period the Respondent administered an anesthetic level amount of Ketamine to PR without continuous monitoring PR's cardiopulmonary levels during these treatment sessions. Additionally, on at least nine occasions during this time period Dr. Hiemstra noted in his medical notes that PR was having problems involving "roaming incidents," falling, and ambulation after being given huge amounts of Ketamine. (In his November 3, 2019 notes for PR, the Respondent states, "I remain concerned about her Ketamine influenced trips to the bathroom which are always, of course,

dangerous enterprises. Paige does not always take the walker to the restroom.") These observations did not, however, stop the Respondent from administering what Dr. Hiemstra, himself, described as "Olympian" dosages of Ketamine to PR (November 17, 2018 medical records).

Lastly, Dr. Hiemstra did not stop giving PR mega-doses of Ketamine even after a staff member told him that PR was being given "crazy" amounts of Ketamine and that PR was falling when she tried to go to the restroom. Especially concerning are the Respondent's February 16, 2019 notes for PR which discuss using a padded room of sorts to deal with the issue of PR's falls. This note was made on a day where PR was given 2000 mg of Ketamine. At the next treatment session, March 4, 2019, PR was again given 2000 mg of Ketamine.

Therefore, the Respondent has engaged in a pattern of negligent or incompetence by giving PR excessive dosages of Ketamine on at least 33 occasions, by giving her an anesthetic amount of Ketamine on 32 occasions without continuously monitoring PR's cardiovascular functions, by continuing to give PR mega-doses of Ketamine despite knowing PR was becoming disoriented and falling after being given these huge amounts of Ketamine, and by continuing to give PR these Olympian dosages of Ketamine even after a staff member told the Respondent that these dosages were "crazy."

In addition to the negligence and incompetence associated with these 33 mega-dosages of Ketamine, Dr. Hiemstra also violated two key provisions of the AMA Code of Medical Ethics by engaging in this negligent conduct. He failed to provide PR with competent medical care, and he failed to regard responsibility to PR as paramount.

Therefore, the Respondent has engaged in unprofessional conduct with PR on at least 33 occasions pursuant to Utah Code Ann. § 58-1-501(2)(b) and (g), Utah Admin. Code R156-67-502(15), and Sections I and VIII of the Preamble of the AMA Code of Medical Ethics. Hiemstra's unprofessional conduct gives the Division the legal authority to impose sanctions against his professional licenses pursuant to Utah Code Ann. § 58-1-401(2)(b).

Again, a number of aggravating circumstances apply in the Respondent's treatment of PR which justify an increase in the severity of the disciplinary action taken against his professional licenses. There was a pattern of misconduct and multiple offenses in this case. Additionally, PR, was an especially vulnerable victim who was repeatedly falling after being given mega-doses of Ketamine when going to the restroom. Lastly, it is especially concerning that on December 21, 2018, the Respondent admitted in his medical notes that he gave PR Ketamine from his "Portuguese Ketamine stock." Using non-FDA approved prescription drugs exposes patients to drugs that may not be safe and effective, and drugs that may not be manufactured in a way that ensures consistent drug quality. Further, this practice raises questions as to whether or not Dr. Hiemstra violated state and federal law by improperly possessing, importing and using adulterated drugs and/or counterfeit substances (pursuant to 21 U.S.C. §331(a) and (aa) and Utah Code Ann. § 58-37-8(1)).

COUNTS LXIII-LXX:
UNPROFESSIONAL CONDUCT ASSOCIATED WITH THE CARE OF PATIENT KC: *A PATTERN OF INCOMPETENCY OR NEGLIGENCE AND A PATTERN OF* VIOLATIONS OF THE AMA CODE OF MEDICAL ETHICS.

44. Paragraphs 1 through 32 are incorporated herein and by this reference made a part hereof.

45. As described in Paragraph 20, the Respondent's assistant failed to immediately call Dr. Hiemstra to discuss KC's concerns that the prior 110 mg doses of Ketamine were too high, causing her headaches, and making her feel angry and disoriented. Additionally, the Respondent's assistant actually tried to get KC to agree to an increased dosage of Ketamine after hearing KC's concerns, and the assistant did not offer or suggest to KC that she have her oxygen levels and blood pressure continuously monitored because of her concerns. Further, the Respondent failed to immediately call for emergency medical personnel after KC's oxygen levels dropped into the 70's and after KC was completely unresponsive verbally and physically. Further, Dr. Hiemstra tried to convince SW to take KC to the hospital rather than have emergency personnel transport KC. Lastly, there was no panic button or other method of communication in the treatment room for KC or SM to use when the medical emergency occurred.

In addition to these six examples of negligence and incompetence associated with KC's emergency situation on September 6, 2019, the Respondent also violated two key provisions of the AMA Code of Medical Ethics by engaging in this negligent conduct. He failed to provide KC with competent medical care, and he failed to regard responsibility to KC as paramount. Alarmingly, he instead tried to downplay the seriousness of the incident, and his assistant actually tried to give KC a larger dose of Ketamine after KC specifically requested a lower dosage. Therefore, Dr. Hiemstra has engaged in unprofessional conduct with KC on at least eight occasions pursuant to Utah Code Ann. § 58-1-501(2)(b) and (g), Utah Admin. Code R156-67-502(15), and Sections I and VIII of the Preamble of the AMA Code of Medical Ethics. The

Respondent's unprofessional conduct gives the Division the legal authority to impose sanctions against his professional licenses pursuant to Utah Code Ann. § 58-1-401(2)(b).

Again, a number of aggravating circumstances apply in the Respondent's treatment of KC which justify an increase in the severity of the disciplinary action taken against the Respondent' s professional licenses. There was a pattern of misconduct and multiple offenses in this case. Additionally, KC, was an especially vulnerable victim who experienced a medical emergency on September 6, 2019 and had to be taken from the Respondent's clinic in an ambulance to a Murray hospital. Lastly, it is especially concerning that on September 6, 2019 the Respondent's assistant actually tried to get KC to take more Ketamine after KC specifically told her that she was concerned about being given too high a dosage.

WHEREFORE, the Division requests the following relief:

1. That the Respondent be adjudged and decreed to have engaged in the acts alleged herein;

2. That by engaging in the above acts, the Respondent be adjudged and decreed to have violated provisions of the Division of Occupational and Professional Licensing Act and the Utah Medical Practice Act;

3. That the Respondent's license to practice as a physician and surgeon in the State of Utah be revoked;

4. That appropriate sanctions, such as a suspension, a mandated physical, mental, substance abuse and/or comprehensive psychological/psychiatric evaluation; educational classes, appropriate counseling, a probationary license, fines, a DOPL-approved supervisor and other

relevant disciplinary actions, be imposed against the Respondent's license to practice as a physician and surgeon in the State of Utah.

Respectfully submitted this 14th day of November, 2019.

Dan Lau, AAG

STATE OF UTAH)
: ss
COUNTY OF SALT LAKE)

Tim Hibler, being first duly sworn, states as follows:

1. I am an investigator for the Bureau of Investigation, Division of Occupational and Professional Licensing (DOPL), and have been assigned to investigate this case.

2. I have read the foregoing Petition and am familiar with the contents thereof. All of the factual allegations in the Petition are true to the best of my knowledge, information and belief.

Tim Hibler
Investigator, DOPL

SWORN TO AND SUBSCRIBED before me this 16 day of November, 2019.

NOTARY PUBLIC
COLLEEN GONZALEZ
Commission No. 699168
Commission Expires
FEBRUARY 26, 2022
STATE OF UTAH

NOTARY PUBLIC