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

In the Matter of the Accusation and Petition to Revoke Probation Against: **Tuan Ahn Doan, M.D.** **Physician's and Surgeon's Certificate No. G 77825** **Respondent.**	**Case No.: 800-2018-047615**

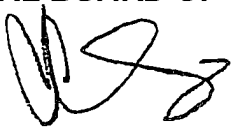
DECISION

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

This Decision shall become effective at 5:00 p.m. on September 23, 2022.

IT IS SO ORDERED: August 26, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
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STEVEN D. MUNI
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: **TUAN ANH DOAN, M.D.** **1230 Sunset Blvd, Ste. 400** **Rocklin, CA 95765-3781** **Physician's and Surgeon's Certificate No. G 77825** Respondent.	Case No. 800-2018-047615 OAH No. 2021100754 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Aaron L. Lent, Deputy Attorney General.

2. Respondent Tuan Anh Doan, M.D. (Respondent) is represented in this proceeding by attorney Dr. Bruce W. Ebert, Esq., whose address is: Law Office of Dr. Bruce W. Ebert, 3400 Douglas Blvd., Ste. 250, Roseville, CA 9566.

3. On or about October 27, 1993, the Board issued Physician's and Surgeon's Certificate No. G 77825 to Tuan Anh Doan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation and Petition to Revoke Probation No. 800-2018-047615, and will expire on March 31, 2023, unless renewed.

4. On or about January 5, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case No. 800-2014-007305, Respondent's license was revoked with the revocation stayed and his license was placed on two years' probation with terms and conditions.

5. On or about November 30, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case No. 800-2017-031593, Respondent's license was revoked with the revocation stayed and his license was placed on three years' probation with terms and conditions.

JURISDICTION

6. Accusation and Petition to Revoke Probation No. 800-2018-047615 was filed before the Board, and is currently pending against Respondent. The Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on August 20, 2021. Respondent timely filed his Notice of Defense contesting the Accusation and Petition to Revoke Probation.

7. A copy of Accusation and Petition to Revoke Probation No. 800-2018-047615 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2018-047615. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

9. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation and Petition to Revoke Probation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to

testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

11. Respondent understands and agrees that the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2018-047615, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

12. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2018-047615 and that he has thereby subjected his license to disciplinary action.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2018-047615 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

RESERVATION

15. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

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

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

19. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 77825 issued to Respondent Tuan Anh Doan, M.D. is revoked. However, the revocations are stayed and Respondent is placed on probation for two (2) years on the following terms and conditions. Once adopted by the Board, the stipulated settlement and disciplinary order contained in Accusation

and Petition to Revoke Probation No. 800-2018-047615, will run consecutive and supersede the terms of probation in Decision and Order No. 800-2017-031593. All terms and conditions of probation in Decision and Order No. 800-2017-031593 have been incorporated into the stipulated settlement in Accusation and Petition to Revoke Probation No. 800-2018-047615. Upon the effective date of the Decision and Order in Accusation and Petition to Revoke Probation No. 800-2018-047615, and once the time to challenge the matter has run, the probationary-terms contained in Decision and Order No. 800-2017-031593 will terminate.

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

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

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation and Petition to Revoke Probation, but prior to the effective date of the Decision may,

in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

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

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

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

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal

relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the

name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an

appropriate practice setting is established

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

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

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

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

9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, joint investigations, and subpoena enforcement, as applicable, in the amount of $23,987.50 (twenty-three thousand nine hundred eighty-seven dollars and fifty cents). Said costs shall be reduced by 50% to $11,993.75 (eleven thousand nine hundred ninety-three and seventy-five cents) if paid in full not later than 120 calendar days prior to the completion of probation. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

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

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

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

Controlled Substances; and Biological Fluid Testing.

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

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

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

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

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18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2018-047615 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 03/31/2022

TUAN ANH DOAN, M.D.
Respondent

I have read and fully discussed with Respondent Tuan Anh Doan, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 3/31/2022

DR. BRUCE W. EBERT, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 3/31/2022

Respectfully submitted,

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

AARON L. LENT
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation and Petition to Revoke Probation
800-2018-047615

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Attorneys for Complainant

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **TUAN ANH DOAN, M.D.** **1230 Sunset Blvd, Ste. 400** **Rocklin, CA 95765-3781** **Physician's and Surgeon's Certificate No. G 77825,** Respondent.	Case No. 800-2018-047615 **ACCUSATION AND PETITION TO REVOKE PROBATION**

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 or about October 27, 1993, the Medical Board issued Physician's and Surgeon's Certificate No. G 77825 to Tuan Anh Doan, 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 March 31, 2023, unless renewed.

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3. In a disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.*, Case No. 800-2017-031593, the Medical Board of California, issued a Decision, effective November 30, 2018, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of three (3) years with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

JURISDICTION

4. This Accusation and Petition to Revoke Probation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws and the Medical Board's Decision in the case entitled, *In the Matter of the Accusation Against Tuan Anh Doan, M.D.*, Case No. 800-2017-031593. 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.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states, in pertinent part:

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

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

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

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

(d) Incompetence.

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6. Section 2228.1 of the Code states, in pertinent part:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

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7. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Section 4021 of the Code states: 'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

10. Section 4022 of the Code states: 'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing

without prescription,' 'Rx only,' or words of similar import.

"...

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

PERTINENT DRUG INFORMATION

11. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is a short-acting medication commonly used for the short-term management of anxiety disorders. Specifically panic disorder or generalized anxiety disorder, Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Amphetamine sulfate tablets – Generic name for the drug Evekeo. Amphetamine sulfate tablets are used for the treatment of narcolepsy, ADDH (attention deficit disorder with hyperactivity) and exogenous obesity. Side effects can include palpitations, tachycardia, elevation of blood pressure and cardiomyopathy. Amphetamine sulfate tablets can be used recreationally as an aphrodisiac and euphoriant. Amphetamine sulfate tablets are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. They are a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

13. Buprenorphine – Generic name for Butrans which is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 §1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code §4022.

14. Deltasone – Generic name for Prednisone. It is in a class of medications called corticosteroids used to treat patients with low levels of corticosteroids by decreasing the immune

system's response to various diseases to reduce symptoms such as swelling and allergic-type reactions.

15. Diethylpropion – Generic name for Tenuate and Tepanil. It is a central nervous system stimulant drug of the phenethylamine, amphetamine, and cathinone classes that is used as an appetite suppressant. Diethylpropion is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

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

18. Indomethacin – Generic name for Indocin. It is a nonsteroidal anti-inflammatory drug (NSAID) used to treat inflammation and pain.

19. Levo-Dromoran – Generic name for Levorphanol. It is a synthetic opioid that is used as a narcotic analgesic to relieve moderate to severe pain. Levorphanol is a Schedule II controlled

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[2] Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Lisdexamfetamine – Generic name for Vyvanse. It is a central nervous system stimulant and amphetamine derivative used to treat ADHD and binge-eating disorders. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Methylphenidate – Generic name for Ritalin. Methylphenidate is a stimulant drug used to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy. Methylphenidate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308. 12. Methylphenidate is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

23. Mixed amphetamine salts – Generic name for Adderall and Mydayis. Mixed amphetamine salts are used in the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. They can be used recreationally as an aphrodisiac and euphoriant. Mixed amphetamine salts are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Mixed amphetamine salts are a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

24. Oxycodone with Acetaminophen– Generic name for Endocet and Percocet. It is an opioid analgesic combination product used to treat moderate to severe pain. Oxycodone and acetaminophen is a dangerous drug pursuant to California Business and Professions Code section

4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

25. Phentermine – Phentermine, also known as dimethylphenethylamine, is a psychostimulant drug of the substituted amphetamine chemical class, with pharmacology similar to amphetamine. It is used medically as an appetite suppressant for short-term use, as an adjunct to exercise and reducing calorie intake. Phentermine is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Testosterone – Generic name for the drugs Striant, Natesto, AndroGel, Androderm, Axiron, Depo-testosterone and Testopel. Testosterone is a medication and naturally occurring steroid hormone used for the treatment of male hypogonadism, and gender dysphoria. Long-term adverse effects of testosterone therapy can include cardiovascular disease and prostate cancer. Testosterone is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13, subdivision (f). It is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule III controlled substance pursuant to California Health and Safety Code section 11055 subdivision (f).

27. Tramdol – Generic name for name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, Tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c).

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FACTUAL ALLEGATIONS

28. Respondent is a physician and surgeon, board certified in family medicine, who at all times relevant to the allegations brought herein worked within Placer County, California.

Patient 1[3]

29. Patient 1, a 35 year-old male patient, was employed in the education field and had dealt with opioid dependency for a number of years prior to becoming Respondent's patient. Patient 1 had previously received opioid therapy for lower back pain, and he sought Respondent's assistance in getting off of opioid medications. Respondent treated Patient 1 from approximately October 2014 to November 2018 in his private medical practice for issues including drug dependency, attention disorders, and low testosterone levels. During that period, Patient 1 continued to receive treatment from his primary care physician at Kaiser Permanente for general medical concerns. Between November 2018 and March 2019, Patient 1 continued to receive controlled substances as a result of Respondent's prescriptions following his last visit in November 2018.

30. On October 27, 2014, Patient 1 signed a written agreement with Respondent that he would submit to biological fluid testing, that he would only receive prescriptions from one provider and one pharmacy during treatment, and that he would use medication as prescribed. The agreement did not set forth a penalty for potential violations. On September 15, 2017, Patient 1 signed a longer patient agreement with Respondent, which stated that Patient 1 would submit to biological fluid testing, receive medications from one pharmacy, that he would use medications as prescribed, and not take controlled substances or illegal drugs from sources other than Respondent. The longer agreement specifically stated that Patient 1 understood that violations of the agreement might lead to a loss of continued treatment. The October 27, 2014, and September 15, 2017, pain agreements did not mention any of the risks and benefits of controlled substance therapy. On October 11, 2017, Patient 1 and Respondent entered into a third opioid patient-prescriber agreement. The third agreement was five pages long, set forth possible

[3] To protect the privacy of the patients and witnesses involved, the patients and witnesses names were not included in this pleading. Respondent is aware of the identity of each patient and witness, all patients and witnesses will be fully identified in discovery.

side effects and risks, and provided information regarding impairment related to opioid therapy. The third agreement listed Patient 1's prescriptions for methylphenidate and Suboxone. The third agreement indicated that Patient 1 would not take illegal substances, drink alcohol, or obtain medications from other prescribers.

31. Between July 2015 and November 19, 2018, Respondent prescribed Suboxone to Patient 1 on an on-going basis. Prescription doses ranged from 2/.05 mg strips to 12/3 mg strips. The typical prescription for Suboxone provided to Patient 1 from Respondent appeared to be a 30-day supply of 30 to 60 quantity 8/2 mg strips. Respondent prescribed Suboxone to Patient 1 to help Patient 1 deal with his past addiction issues to opioid pain medication. In addition to Suboxone treatment, Respondent also prescribed lorazepam, Ritalin, Evekeo, and Adderall to Patient 1. Between July 29, 2015, and December 29, 2015, Patient 1 received approximately 270 tablets of 1 mg lorazepam and 10-20 mg tablets of Ritalin. Between December 30, 2015, and April 11, 2016, Patient 1 received approximately 360 tablets of 1 mg lorazepam and 285 tablets of 20 mg Ritalin. Between April 11, 2016, and July 18, 2016, Patient 1 received approximately 270 tablets of 1 mg. lorazepam, 360 tablets of 20 mg Ritalin, 60 tablets of 10 mg Evekeo, and 60 tablets of 20 mg Adderall. Between July 29, 2016, and November 3, 2016, Patient 1 received approximately 228 tablets of 1 mg lorazepam, 357 tablets of 20 mg Ritalin, and 60 tablets of 30 mg Adderall. Between November 9, 2016, and February 3, 2017, Patient 1 received 270 tablets of 1 mg lorazepam, 436 tablets of 20 mg Ritalin, and 120 tablets of 30 mg Adderall.

32. Between February 25, 2017, and May 21, 2017, Patient 1 received approximately 99 tablets of 1 mg lorazepam, 440 tablets of 20 mg Ritalin and 240 tablets of 30 mg Adderall. Between May 21, 2017, and August 23, 2017, Patient 1 received approximately 240 tablets of 1 mg lorazepam, 360 tablets of 20 mg Ritalin, and 180 tablets of 30 mg Adderall. Between August 23, 2017, and January 10, 2018, Patient 1 received approximately 60 tablets of 1 mg lorazepam, 360 tablets of Ritalin, 240 tablets of 30 mg Adderall. Between January 12, 2018, and May 26, 2018, Patient 1 received approximately 120 tablets of 1 mg lorazepam, 240 tablets of 20 mg Ritalin, and 120 tablets of 30 mg Adderall. Between June 11, 2018, and March 16, 2019, Patient 1 was prescribed approximately 300 tablets of 1 mg lorazepam, and 600 tablets of 30 mg

Adderall. At his July 29, 2020, interview with the a Department of Consumer Affairs Health and Quality Investigation Unit (HQIU) Investigator, Respondent stated that Patient 1 was prescribed both Adderall and Ritalin but that Patient 1 did not take the medications at the same time. However, prescription records indicate that between May 26, 2016, and November 4, 2017, Patient 1 filled prescriptions for Adderall and Ritalin within one month of each other on approximately nine occasions. Respondent did not document whether Patient 1 was overusing stimulant medication and did not perform pill counts.

33. During the July 29, 2020 interview, the HQIU Investigator asked Respondent about prescribing Evekeo to Patient 1. Respondent incorrectly stated to the HQIU Investigator that Evekeo was a brand name for naloxone, an opioid reversal agent. Evekeo is a stimulant in the same class as Adderall and is a Schedule II controlled substance, not an opioid reversal agent.

34. Between July 2015 and November 19, 2018, Respondent repeatedly failed to properly document Patient 1's medical records. On January 26, 2016, Respondent failed to provide a medical rationale in Patient 1's medical record for prescribing lorazepam and Ritalin to Patient 1. On June 16, 2016, Respondent failed to document a medical rationale in Patient 1's medical record for increasing the dose of Patient 1's prescription for Ritalin. On July 7, 2016, Respondent failed to document a medical rationale in Patient 1's medical records for increasing the dose of Patient 1's prescription of Suboxone and for prescribing Evekeo, which as noted above is a Schedule II controlled substance. On January 12, 2017, Respondent failed to document a medical rationale in Patient 1's medical records for prescribing testosterone, a Schedule III controlled substance, to Patient 1 and Respondent failed to conduct testing on that date to establish that Patient 1 required testosterone. On March 13, 2017, Respondent failed to document a rationale in Patient 1's medical records for increasing the dose of Patient 1's prescription for Suboxone.

35. On or about May 10, 2018, June 11, 2018, and July 13, 2018, Patient 1 received 120 tablets of 30 mg Adderall as a result of Respondent's prescriptions. If taken as prescribed, Patient 1 was taking 120 mg of Adderall daily, significantly above the upper safe recommended dose limit of 60 mg of Adderall daily. Respondent did not document in Patient 1's medical record why

this excessive dosage was appropriate, nor did he note whether he had balanced the risks versus benefits of providing such a high dose of Adderall to Patient 1. On or about August 20, 2018, Respondent documented that Patient 1 had recently been seen in the hospital for idiopathic Afib (an irregular and often rapid heart rate). Cardiac arrhythmias are a known side effect of amphetamine use. Respondent failed to document a further discussion of this cardiac event and/or whether Patient 1's high dose of Adderall could have caused Patient 1's serious medical issue.[4]

36. Between July 2015 and November 19, 2018, there were a series of concerns documented in Patient 1's medical chart that indicated he was a poor candidate for long-term controlled substance therapy provided by Respondent. On or about August 23, 2016, Patient 1 refilled his lorazepam prescription six days early. On or about September 14, 2016, Patient 1 refilled his Adderall prescription 18 days early. On or about December 21, 2016, Patient 1 refilled his lorazepam prescription 7 days early. On or about January 17, 2017, Patient 1 refilled his Ritalin prescription 12 days early. None of these early refills were documented in Patient 1's medication record as potential red flags. On or about August 25, 2016, Patient 1 reported that his medication was stolen from a rental vehicle. Respondent stated to the HQIU Investigator during an interview that Patient 1 had made a police report but Respondent admitted he didn't document that in his record and had no record of requesting and/or obtaining the police report for inclusion in Patient 1's medical record. On or about August 23, 2017, Patient 1 reported accidentally throwing out his Suboxone strips and needing more medication.

37. On or about April 11, 2016, Patient 1 reported that he had doubled up on doses of Suboxone and that he had run out of medication early. On or about January 16, 2018, Patient 1 reported taking more Suboxone than prescribed. On or about April 4, 2018, Patient 1 reported taking more Suboxone than prescribed and that he was experiencing withdrawal symptoms of rhinorrhea and abdominal cramping. Between July 2015 and November 19, 2018, Patient 1 repeatedly provided biological fluid samples with inconsistent drug screens to the medications he

[4] On or about July 11, 2018, Patient 1 provided a biological fluid sample, which indicated that his amphetamine quantification was 23718.719 ng/mL.

was supposed to be prescribed, and reported relapses to opioid medication. On or about December 30, 2015, a drug screen showed the presence of hydromorphone, a powerful opioid, in violation of the pain management agreement. On or about February 24, 2016, Patient 1 provided a drug screen that didn't show the presence of Ritalin despite Patient 1 receiving a prescription for 60 tablets of 20 mg Ritalin on or about February 4, 2016. On or about November 3, 2016, Patient 1 reported a relapse where he had taken Norco, a Schedule II controlled substance, from his father. Respondent noted that Patient 1 stated he took the Norco in violation of his controlled substances agreement because he had jury duty and could not see the Respondent for follow-up. On or about April 18, 2017, Respondent sent Patient 1 a warning letter that Patient 1 had provided a urine drug screen which showed that he had been taking opioids, and that he risked being discharged from the practice if he had any further violations of the controlled substances agreement. The warning letter and the medical records are unclear as to the specific urine drug screen to which they are referring, but on or about March 13, 2017, Patient 1 provided a drug screen that was inconsistent for the presence of Norco.

38. Between July 2015 and November 19, 2018, Respondent documented a number of concerns related to Patient 1 continuing long-term controlled substance treatment. On or about February 24, 2016, and May 6, 2016, Respondent documented that Patient 1 was treated for depression. Between October 29, 2014, and March 17, 2019, Patient 1 received prescriptions from ten separate pharmacies in violation of the controlled substances agreements that he had with Respondent. At his interview with the HQIU Investigator on or about July 29, 2020, Respondent stated that Patient 1 had an option to refer Patient 1 back to Kaiser for multidisciplinary treatment when Patient 1 had issues with treatment, but that Kaiser was too restrictive, and so Respondent tried "to manage the best I can." Respondent acknowledged that, "(y)es, ideally, I should have refer him back to Kaiser, but I chose to keep him to manage the best of my best ability."

39. Between July 2015 and November 19, 2018, Respondent failed to evaluate and/or document Patient 1's progress towards treatment objectives as part of an on-going assessment, and evaluate Patient 1's functional goals, side effects and aberrant behaviors. Between July 2015

and November 19, 2018, Respondent failed to create a treatment plan, including specifying goals and objectives of treatment while prescribing benzodiazepines, stimulants, and Suboxone. Between July 2015 and November 19, 2018, Respondent failed to provide informed consent and/or document that he clearly explained the risks of long term, high dose, and excessive dose of stimulant prescriptions. Between July 2015 and November 19, 2018, Respondent failed to evaluate and/or document whether he evaluated Patient 1 for a diagnosis of ADD, anxiety and/or low testosterone prior to prescribing benzodiazepines, stimulants, and/or testosterone.

Patient 2

40. Patient 2 established care with Respondent on or about August 20, 2018. Respondent documented that Patient 2 had no acute medical conditions and listed no concerns under the problem list. Under impression, Respondent documented that he performed a general adult medical exam on Patient 2 with no abnormal findings. Respondent ordered biological fluid testing for Patient 2 including testosterone level, lipid panel, and thyroid studies. On or about August 20, 2018, labs were collected and the results indicated that the patient had hyperlipidemia, a normal[5] testosterone level of 406 ng/dL and a uric acid level of 5.0 mg/dL. On or about August 20, 2018, Respondent also refilled Patient 2's prior prescription for tramadol. On August 20, 2018, and subsequent visits with Patient 2, Respondent failed to document any discussion with Patient 2 regarding what medical issue Respondent was treating with tramadol.

41. On or about December 17, 2018, Patient 2 presented in Respondent's clinic to discuss the lab results from August 20, 2018, and his medical issues. Respondent documented that Patient 2 needed testosterone, Lipitor (used to treat elevated cholesterol), and Cialis (an erectile dysfunction medication). Respondent did not document a physical examination. In the assessment and plan, Respondent documented that Patient 2 had testicular hypofunction and noted that he would start Patient 2 on Depo-testosterone. Respondent failed to document a medical rationale for providing exogenous testosterone to Patient 2 who had normal testosterone levels as indicated by the August 20, 2018, lab results. Respondent failed to document whether

[5] According to the laboratory report, a normal reference range for testosterone is 264-916 ng/dL, citing Tavison et. al. JCEM 2017, 1021 1161-1173. PMID: 28324103.

Patient 2 had any symptoms of testicular hypofunction, and whether he discussed the long-term risks and side effects of being prescribed exogenous testosterone with Patient 2.

42. On approximately 12 occasions between December 21, 2018, and June 19, 2019, Patient 2 presented at Respondent's office to receive testosterone injections. Despite repeated visits to Respondent's clinic over that time, Patient 2 only observed Respondent, Respondent's medical assistant, and Respondent's receptionist working at the clinic and never saw or was treated by any other licensed medical professionals. On or about January 30, 2019, Patient 2 provided a biological fluid sample for testing. The labs indicated that Patient 2 had a testosterone level of 1488 ng/dL which was out of normal range and well above the 916 ng/dL reference level. Respondent did not make changes to Patient 2's testosterone dosing despite this laboratory result. On or about June 4, 2019, Respondent documented that Patient 2 was seen for shortness of breath. Respondent documented that Patient 2 had shortness of breath at night since a bout of bronchitis, and that he continued to smoke, and diagnosed him with chronic obstructive pulmonary disease (COPD). Respondent did not document any discussion related to Patient 2's abnormally high testosterone level in any of the progress notes between January 30, 2019, and June 19, 2019.

43. On or about June 19, 2019, Respondent documented that Patient 2 had knee pain for the past three days. On physical examination, Respondent documented left knee tenderness, warmth, pain on internal rotation and edematous (visible swelling). Respondent diagnosed the patient with gout in his impression and ordered a uric acid level test. Respondent prescribed prednisone and continued Patient 2 on testosterone. The uric acid test was normal with a result of 4.5 mg/dL and that result was consistent with the test done on or about August 21, 2018. The uric acid test was not consistent with Respondent's diagnosis of gout. Respondent did not make any changes to his diagnosis of gout following the reporting of Patient 2's uric acid test result on or about June 20, 2019. Respondent did not work up Patient 2 for a possible deep vein thrombosis (DVT) despite having Patient 2 on testosterone replacement therapy.

44. On or about June 23, 2019, Patient 2 continued to experience swelling to his legs and he was in a great deal of pain. Patient 2 went to the emergency department at Sutter Medical Center-Roseville. Patient 2 was diagnosed as having a series of heart attacks. Patient 2 was

instructed to stop taking prednisone and testosterone. Patient 2 was later transferred to Mercy General Hospital where he underwent a heart procedure.

45. On or between August 20, 2018, and June 19, 2019, Respondent failed to provide informed consent to Patient 2 and/or document the potential risks and side effects of long-term testosterone therapy, including possible cardiovascular harm. On or between August 20, 2018, and June 19, 2019, Respondent failed to create and/or document a treatment plan with objectives for Patient 2's treatment. On or between February 1, 2019, and June 19, 2019, Respondent failed to order follow-up laboratory testing with Patient 2 after receiving a high testosterone level on or about January 30, 2019. On or between February 1, 2019, and June 19, 2019, Respondent failed to adjust Patient 2's testosterone dosing, failed to discuss the lab result from January 30, 2019, with Patient 2, and failed to ask Patient 2 if he was experiencing side effects from testosterone treatment. Between August 20, 2019, and June 19, 2019, Respondent failed to document diagnosis, treatment rationales, and treatment outcomes for testosterone treatment and Tramadol treatment in Patient 2's medical record.

Patient 3

46. On or about May 21, 2015, Patient 3, a female patient, was seen by Respondent at the Doan Family Medicine facility located in Rocklin, California, for the execution of an opiate/pain management agreement with Respondent. The opiate/pain management agreement did not state or discuss any risk of respiratory depression, motor impairment, cognitive impairment, and/or death in relation to the use of opioids. Prior to that date, Respondent first began treating Patient 3 in 2014 for migraines and headache pain.

47. On or about January 7, 2016, Patient 3 was seen by Respondent for continuing complaints of migraine headaches. Respondent prescribed Patient 3 with 120 tablets of 325-10 mg Percocet for her migraine headache pain and 30 tablets of 75 mg Tenuate as a diet medication.

48. On or about February 5, 2016, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement with Respondent. Respondent refilled Patient 3's medications for 120 tablets of 325-10 mg Percocet and 30 tablets of 75 mg Tenuate. Respondent also obtained a drug screen from Patient 3, which showed that Patient 3 was negative for

hydrocodone, norhydrocodone, and hydromorphone, but did not appear to indicate whether Patient 3 was screened/tested for the presence of Percocet or oxycodone. Patient 3's medical records for this visit with Respondent do not specify measurable goals or objectives used to evaluate Patient 3's progress, and they do not include an articulated treatment plan, rationale for treatment, or outcomes of Patient 3's treatments.

49. On or about February 27, 2016, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraine. Patient 3 reported her pain was 10/10 and that the amount of pain relief she was obtaining from her current pain relievers was not enough to make a difference in her life. Patient 3 also reported worsening sleep patterns since starting the pain medication. Respondent noted that Patient 3 had frequent early medication renewal requests and had increased her dosage without authorization. Respondent continued Patient 3's current regimen without change.

50. On or about March 30, 2016, Patient 3 was seen by Respondent for a refill of her opioid medication for her migraines. Respondent noted that "with new CDC guidelines, her opioid needs to be wean down and off." Respondent noted his intent to reduce Patient 3's Percocet 325-10 mg to 100 tablets per month and to refer her to pain management. On or about April 28, 2016, Respondent saw Patient 3 for a follow-up for her migraines. Patient 3 informed Respondent that she still had migraines which had recently increased. Respondent refilled her 100 tablets of 325-10 mg Percocet despite noting 90 tablets in the medical record under current medications. He also obtained a drug screen from Patient 3, which showed a consistent positive result for oxycodone and its metabolites, and negative for all other listed drugs. On or about May 26, 2016, Respondent obtained a drug screen from Patient 3, which yielded results that were inconsistently positive for morphine. There is no indication in Patient 3's medical records of any further or additional testing or retesting of this result.

51. On or about June 22, 2016, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement. Patient 3 reported having a therapeutic abortion (TAB) and additional uterine cramping. Respondent prescribed Indocin to Patient 3; however, there is no indication in the medical record of Patient 3 being informed of the side effects of Indocin,

especially when combined with alcohol, such as an increased risk of gastrointestinal-related side effects or kidney damage. On or about July 12, 2016, Patient 3 was again seen for a follow-up to her opiate/pain management agreement. Patient 3 reported her pain was 5-6/10 and that approximately 70% of her pain has been relieved on her current medications. Respondent referenced Patient 3's last drug screen from May 26, 2016 in the medical record but did not discuss the inconsistent result of a positive drug screen for morphine. Respondent continued Patient 3's current regimen without change.

52. On or about August 18, 2016, Patient 3 was seen by Respondent for complaints of headaches, and reported severe fatigue for the prior three months with a headache upon waking each morning. Patient 3 also reported discontinued use of Topamax (an anti-migraine medicine). Respondent refilled her Percocet prescription but increased the dosage to 120 tablets of 325-10 mg; however, the medical record contains no discussion regarding this increased dosage. On or about September 14, 2016 and October 12, 2016, Patient 3 was seen by Respondent for complaints of migraine headaches, to which Respondent continued her on 120 tablets of Percocet at 325-10 mg. Respondent obtained drug screens from Patient 3 on both September 14, 2016 and October 12, 2016, both of which showed that Patient 3 was negative for all drugs tested, but they did not appear to indicate whether Patient 3 was tested for the presence of Percocet or oxycodone in either drug screen.

53. On or about November 3, 2016, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraine. Patient 3 reported her pain was 5-6/10 and that approximately 60% of her pain has been relieved on her current medications. Respondent noted that Patient 3 self-reported the use of alcohol socially, and Respondent documented in the medical record the same risk and benefit language he used in his previous pain management assessments without mention of the patient's alcohol use. On or about November 19, 2016, Patient 3 was again seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraine. Patient 3 reported her pain was 5-6/10 but, inconsistent with two weeks prior, she now reported 70% of her pain was relieved on her current medications, and

Respondent noted Patient 3 was not consuming alcohol socially. Respondent continued Patient 3's current regimen without change.

54. On or about January 7, 2017, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraines. Patient 3 reported her pain was 5-8/10, that approximately 60% of her pain has been relieved on her current medications, and the medical record indicated she was not consuming alcohol socially. Respondent continued Patient 3's current regimen without change. On or about January 25, 2017, Patient 3 was again seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraines which Patient 3 reported as being exacerbated by her employment situation. Patient 3 also reported her pain was 6-8/10 and that approximately 60% of her pain has been relieved on her current medications. Respondent continued Patient 3's current regimen without change, and obtained a drug screen from Patient 3 which yielded results that were consistent for oxycodone and metabolites.

55. On or about February 23, 2017, Patient 3 was seen by Respondent for a follow-up to her opiate/pain management agreement and for her migraine. Patient 3 reported her pain was 5-7/10, that approximately 60% of her pain has been relieved on her current medications, and that she lost her employment. Respondent continued Patient 3's current regimen without change.

56. On or about March 18, 2017, Patient 3 was seen by Respondent for complaints of migraine headaches. Respondent noted that there was no change in the pattern of her migraines and still required opioids for pain control. Respondent continued Patient 3's current regimen without change, and obtained a drug screen from Patient 3 which yielded results that were positive for oxycodone and metabolites but also positive for Levorphanol. According to a review of Patient 3's medical records and the CURES[6] reports, there is no indication that the Levorphanol was filled at a pharmacy.

[6] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

57. On or about May 1, 2017, Patient 3 was seen by Respondent for complaints of migraine headaches. Patient 3 reported having a recent motor vehicle accident, and that her migraines were increasing while she was taking 60 MME[7] per day. Respondent noted that Patient 3 had no history of abuse or early refills or diversion of her medication, and stated the patient would be continued on the current dosage of Percocet. Respondent made no mention of Patient 3's last drug screen from March 18, 2017 in the medical record, and did not discuss the inconsistent result of a positive result for Levorphanol. Respondent continued Patient 3's current regimen without change, and obtained a drug screen from Patient 3 which yielded results that were positive for morphine and negative for oxycodone. On or about May 15, 2017, Patient 3 was seen by Respondent to go over the recent lab results and discuss medications. Respondent noted that Patient 3 was prescribed 120 tablets of Percocet at 325-10 mg and noted his intention to schedule her for a bioTE pellet insertion (bio-identical hormone pellet therapy for women).

58. According to a review of Patient 3's medical records and the CURES reports, Respondent prescribed Patient 3 120 tablets of oxycodone at 10 mg on March 7, 2017 where the patient filled an additional 30 tablets on March 18, 2017. No mention was made by Respondent in Patient 3's medical records as to this early refill. On June 1, 2017, Patient 3 filled her Percocet prescription from Respondent four days early. Between July 7, 2017 and September 25, 2017, the patient was given two prescriptions by Respondent for oxycodone at 120 tablets each, and two prescriptions for oxycodone at 30 tablets each. Between September 25, 2017 and April 30, 2018, Patient 3 was given four prescriptions written by Respondent for hydrocodone for a total of 79 tablets from four different providers and one prescriptions for oxycodone at 40 tablets from a fifth provider.

59. On or about April 30, 2018, Patient 3 was seen by Respondent to discuss Suboxone therapy and treatment of heroin addiction. Patient 3 reported using heroin for many months for

[7] Morphine Milligram Equivalents ("MME") and Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf at page 17.

musculoskeletal pain, and subsequently became physically and mentally addicted to heroin. Patient 3 reported she attempted to wean off heroin but had withdrawal symptoms and was afraid to get off opioids whether bought by prescription or on the black market. Respondent diagnosed Patient 3 with opioid abuse and accidental poisoning by heroin. Respondent prescribed Patient 3 Suboxone at 8 mg twice a day and noted in her medical records a discussion about the risks and side effects of medication with a one-month follow-up; however, there is no mention in the record regarding Patient 3's use of multiple providers. Respondent also obtained a drug screen from Patient 3 which yielded results that were positive for amphetamines, cannabinoids and heroin.

60. According to a review of Patient 3's medical records and the CURES reports, on May 1, 2018, Patient 3 filled a prescription for 60 tablets of Suboxone at 8 mg from an unknown prescriber, and on the following day, May 2, 2018, filled an additional 60 tablets of Suboxone at 8 mg from Respondent.

61. According to a review of Patient 3's medical records and the CURES reports, Patient 3 filled prescriptions for the following opioids: from November 14, 2015 to February 5, 2016, the patient received an average of 86 MME per day; from March 1, 2016 to August 8, 2016, the patient received an average of 68 MME per day; from September 16, 2016 to April 5, 2017, the patient received an average of 82 MME per day; and from May 5, 2017 to September 25, 2017, the patient received an average of 69 MME per day. After September 25, 2017, there were five other providers each with four prescriptions for hydrocodone and one prescription for oxycodone ranging from 12 to 40 tablets for Patient 3.

62. According to a review of Patient 3's medical records and the CURES reports, on numerous occasions Patient 3 requested early refills of controlled substances from Respondent, including: January 9, 2016 to February 5, 2016; May 27, 2016 to June 23, 2016; July 22, 2016 to August 18, 2016; September 16, 2016 to September 26, 2016; March 7, 2016 to March 18, 2016; May 5, 2017 to June 1, 2017; and August 22, 2017 to September 1, 2017. In addition, Patient 3 used multiple pharmacies to fill her prescriptions in violation of her May 21, 2015 opiate/pain management agreement with Respondent.

63. On or about May 21, 2015 through April 30, 2018, the vast majority of Patient 3's medical records for her visits with Respondent did not specify measurable goals or objectives used to evaluate Patient 3's progress, did not state the duration, severity, and/or number of headache free days, and did not include an articulated treatment plan, rationale for treatment, or outcomes of Patient 3's treatments.

Patient 4

64. On or about November 9, 2015, Patient 4, a female patient, was seen by Respondent at the Doan Family Medicine facility located in Rocklin, California, for the execution of an opiate detoxification management agreement with Respondent. The opiate detoxification management agreement included the requirements of urine drug screening, CURES report review and the use of only H&H Integrative Pharmacy for prescriptions. Prior to that date, Patient 4 had a history of opioid addiction for back pain.

65. According to a review of Patient 4's CURES reports:

a. On November 12, 2015, Patient 4 filled a prescription from Respondent for 10 tablets of amphetamine salt combo at 30 mg, at H&H Integrative Pharmacy;

b. On November 16, 2015, Patient 4 filled a prescription from another medical provider for 120 tablets of amphetamine salt combo at 20 mg, at a Walmart Pharmacy;

c. On November 19, 2015, Patient 4 filled a prescription from Respondent for 15 tablets of amphetamine salt combo at 30 mg, at H&H Integrative Pharmacy;

d. On November 30, 2015, Patient 4 filled a prescription from Respondent for 15 tablets of amphetamine salt combo at 30 mg, at H&H Integrative Pharmacy;

e. On December 12, 2015, Patient 4 filled a prescription from Respondent for 60 tablets of amphetamine salt combo at 20 mg, at a Target Pharmacy;

f. On December 16, 2015, Patient 4 filled a prescription from another medical provider for 120 tablets of amphetamine salt combo at 20 mg, at a Walmart Pharmacy; and

g. On December 24, 2015, Patient 4 filled a prescription from Respondent for 30 tablets of amphetamine salt combo at 20 mg, at H&H Integrative Pharmacy.

66. On or about December 20, 2016, Respondent obtained Patient 4's CURES report dating from July 20, 2016 through December 8, 2016, which indicated Patient 4 filed prescriptions for Alprazolam and amphetamine salt combo (Adderall) at a Costco Pharmacy that was not listed in the November 9, 2015 opiate detoxification management agreement. Furthermore, Respondent's medical records for Patient 4 did not state a diagnosis and/or treatment plan with a rationale for the Adderall prescription for this time period. According to a review of Patient 4's medical records and the CURES reports, between December 30, 2015 and December 31, 2015, Patient 4 filled prescriptions for Suboxone, Alprazolam, and Adderall from Respondent.

67. On or about January 12, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent obtained a drug screen from Patient 4 that yielded positive results for Suboxone metabolites and amphetamine. However, there was no positive result for Alprazolam. Respondent refilled Patient 4's prescriptions for 90 tablets of Suboxone at 2-0.5 mg and 120 tablets of Adderall at 20 mg. According to a review of Patient 4's CURES reports, Patient 4 was provided a prescription for Alprazolam on or about December 31, 2016, by another medical provider, in violation of the November 9, 2015 opiate detoxification management agreement with Respondent. On or about January 22, 2016, Patient 4 was seen by Respondent to discuss her CURES reports regarding obtaining Adderall from two physicians. Patient 4 reported to Respondent that she had her daughter retrieve the prescription medications from the other medical provider. Even though the utilization of two medical providers and multiple pharmacies are violations of the November 9, 2015 opiate detoxification management agreement, Respondent only discussed the importance of CURES and a single medical provider with Patient 4. On or about January 29, 2016, Patient 4 was seen by Respondent, and reported her Adderall was accidentally washed with her clothing by her daughter. Patient 4 requested Respondent refill her prescription. Respondent refilled Patient 4's Adderall and obtained a drug screen from Patient 4 that yielded positive results for buprenorphine and norbuprenorphine; however, there was an abnormal creatinine level and specific gravity that could indicate a tainted sample.

68. On or about February 4, 2016, Respondent obtained a CURES report dated from August 8, 2015 through January 22, 2016 for Patient 4 which indicated Patient 4 filled a prescription for amphetamine salt combo on December 30, 2015 for 90 tablets from Respondent, but also filled a prescription for amphetamine salt combo on January 19, 2016 for 120 tablets from another medical provider at a Walmart Pharmacy.

69. On or about February 5, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's 60 tablets of Suboxone prescription; however, there is no indication in Patient 4's medical records that Respondent discussed Patient 4's January 18, 2016 filling of 120 tablets of amphetamine salt combo from another medical provider at a Walmart Pharmacy.

70. According to a review of Patient 4's CURES reports, on February 5, 2016, the patient filled a prescription for 6 tablets of Suboxone, on February 8, 2016 she filled a prescription for 10 tablets, and on February 12, 2016 she filled a prescription for 44 tablets. On February 12, 2016 she also filled a prescription for 120 tablets of amphetamine salt combo at 20 mg. On February 18, 2016, Patient 4 filled a 30 tablet prescription for Alprazolam at 1 mg, from another medical provider at a Walmart Pharmacy. On or about March 3, 2016, Respondent obtained a CURES report dated from September 3, 2015 through February 18, 2016 for Patient 4.

71. On or about March 5, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent refilled Patient 4's Suboxone prescription with 56 tablets, prescribed 30 dosages of Vyvanse at 70 mg, and obtained a drug screen from Patient 4. There is no indication in Patient 4's medical records for this visit pertaining to Patient 4 filling a prescription for Alprazolam and its contraindicated use with Suboxone, nor is there any mention as to why Vyvanse was prescribed or why Patient 4 required an early refill of her amphetamines. At an interview with an HQIU Investigator on July 29, 2020, Respondent stated that Patient 4 had gastric bypass surgery and that sometimes her pills would pass through her digestive system, and hoped that the delayed release of the Vyvanse would assist her to absorb the medication. However, on or about April 4, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up,

and Respondent refilled Patient 4's prescriptions for Suboxone and Adderall but not Vyvanse until April 23, 2016 at 30 mg for 70 tablets.

72. On or about May 6, 2016, Patient 4 was seen by Respondent for an attention deficit disorder (ADD) / attention deficit hyperactivity disorder (ADHD) follow-up. Patient reported that during the prior two weeks she had little interest and pleasure doing daily tasks and felt depressed nearly every day. Patient 4 also reported difficulty sleeping, a poor appetite or overeating, and loss of concentration. Respondent noted a score of 21 on the patient health questionnaire (PHQ-9) but no further discussion of Patient 4's depression screening was mentioned in the medical records for this visit. Respondent refilled Patient 4's Suboxone and Adderall approximately seventeen days early. On or about May 20, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up during which the patient reported increasing her own Suboxone dosage to 3 mg after feeling loopy while shopping at 1 a.m. Respondent refilled the patient's prescriptions for 45 tablets of Suboxone at 2-0.5 mg and 120 tablets of Adderall at 20 mg approximately eighteen days early. There was no mention in Patient's 4 medical records regarding the unauthorized Suboxone dosage increase for this month.

73. On or about June 22, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up at which time Respondent refilled Patient 4's Suboxone and Adderall, and added a prescription for 25 tablets of Prednisone at 20 mg. There was no mention in Patient's 4 medical records regarding the rationale for the prescribed Prednisone for this visit. According to a review of Patient 4's medical records and the CURES reports, between April 8, 2016 and June 30, 2016, Patient 4 filled prescriptions for over 240 tablets of amphetamines at 20 mg and 30 tablets of Vyvanse at 70 mg.

74. On or about July 12, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent refilled Patient 4's prescriptions for Suboxone, prescribed 60 tablets of Alprazolam at 0.5 mg, obtained a drug screen, and ordered a set of labs including a metabolic panel which revealed the patient's hemoglobin was very low with a very low iron level. There was no mention in Patient's 4 medical records regarding the lab results on this date nor on subsequent dates of service for Patient 4. Additionally, Patient 4's CURES reports evidence the

patient filling another prescription for Adderall from Respondent on July 22, 2016 for an additional 120 tablets without an explanation provided in the patient's medical record as to this early refill.

75. On or about August 18, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent refilled Patient 4's prescription for Suboxone and Adderall. According to a review of Patient 4's medical records and the CURES reports, on August 16, 2016, Respondent prescribed Patient 4 60 tablets of Alprazolam at 0.5 mg; however, there was no explanation of how or why this occurred in the patient's medical record. Additionally, Patient 4's CURES reports evidence the patient filling another prescription for Adderall from Respondent on August 29, 2016 for an additional 120 tablets. Again, there was no explanation provided in the patient's medical record as to this early refill.

76. On or about September 6, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent noted that Patient 4 was unable to stay on 1 mg dosage of Suboxone, and consequently increased her prescription to 2 mg daily and refilled her Suboxone approximately twelve days early. Respondent also obtained a drug screen from Patient 4 which showed that Patient 4 was positive for Suboxone and amphetamines, but inconsistently positive for Tramadol and Tramadol metabolites.

77. On or about September 13, 2016, Respondent obtained a CURES report for Patient 4, and on or about September 26, 2016, saw Patient 4 for a Suboxone follow-up and noted that "no relapse and last urine drug screen is clear off illicit drugs." However, there was no mention in the medical record of any discussion regarding the positive Tramadol test results from September 6, 2016. Respondent continued Patient 4's current Suboxone regimen without change.

78. On or about October 24, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's prescriptions for Suboxone and Adderall, and obtained a drug screen. According to a review of Patient 4's medical records and the CURES reports, Patient 4 filled a 60 tablet prescription for Alprazolam at 0.5 mg from Respondent on October 12, 2016. On or about November 22, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's prescriptions for Suboxone at

0.25 mg per day and ordered a blood draw to recheck the patient's iron. On or about December 8, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's prescriptions for Suboxone at 0.25 mg twice day, prescribed 28 tablets of methylphenidate at 20 mg, and obtained a drug screen. There were no results provided in Patient 4's medical records for this drug screen, nor was there any explanation for the Suboxone dosage increase. Additionally, Patient 4 CURES reports evidence the patient filling another prescription for methylphenidate from Respondent on December 14, 2016 for an additional 60 tablets, as well as 60 tablets of Alprazolam at 0.5 mg on December 1, 2016. Again, there was no explanation provided in the patient's medical record as to this early refill.

79. On or about December 21, 2016, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's prescription for Suboxone; however, Patient 4's medical records for this visit listed an additional prescription from December 21, 2016 for Suboxone as well as a prescription for methylphenidate on December 14, 2016. There was no mention in Patient's 4 medical records regarding the rationale for the second listed prescription of Suboxone or the additional prescription of methylphenidate for this visit. According to a review of Patient 4's medical records and the CURES reports, between July 8, 2016 and December 1, 2016, Patient 4 filled prescriptions for over 600 tablets of amphetamines at 20 mg and 180 tablets of Alprazolam at 0.5 mg from Respondent.

80. On or about January 14, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, at which time Respondent refilled Patient 4's prescriptions for Suboxone, 120 tablets of Adderall at 20 mg, and prescribed 60 tablets of Xanax at 0.5 mg. In Patient 4's medical records for this visit, there was no discussion of the reasons for the prescriptions of Adderall and Xanax. In the medication list portion of Patient 4's medical records, it states that on January 5, 2017 Respondent prescribed the patient 120 tablets of methylphenidate at 20 mg; however, there was no other mention of this prescription in the patient's record for this visit and no discussion as to the reason Respondent prescribed Adderall and methylphenidate together. On or about January 16, 2017, Respondent obtained a drug screen from Patient 4 which showed that Patient 4 was negative for lorazepam, nordiazepam, tempazepam and oxazepam; however, it does not appear

that the drug screen tested for Alprazolam (Xanax). According to a review of Patient 4's medical records and the CURES reports, Patient 4 filled a prescription for 60 tablets of Alprazolam at 0.5 mg from Respondent on January 26, 2017.

81. On or about February 6, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent noted that at the last office visit, only two weeks' worth of Suboxone and Adderall were prescribed. In the medication list of the medical record, Respondent noted that the patient received a refill of Adderall on January 26, 2017, and in the plan section of the medical record Respondent noted refilling the patient with 15 tablets of Suboxone and 120 tablets of Adderall. According to a review of Patient 4's medical records, in the medication list sections, between January 14, 2017 and February 6, 2017, Respondent prescribed 320 tablets of Adderall to Patient 4. Additionally, Patient 4's CURES reports evidence the patient filling another prescription for Adderall from Respondent on February 18, 2017 for 120 tablets at 20 mg and then again on March 8, 2017 for an additional 70 tablets at 30 mg. Again, there was no explanation provided in the patient's medical record as to this early refill or increase in dosage.

82. On or about March 3, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for 15 tablets of Suboxone, 60 tablets of Adderall at 30 mg, and obtained a drug screen. On or about March 23, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up during which Respondent refilled Patient 4's prescriptions for 8 tablets of Suboxone and 30 tablets of Xanax. On or about April 6, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up during which Respondent refilled Patient 4's prescriptions for 30 tablets of Suboxone, 60 tablets of Adderall at 30 mg, and obtained a drug screen. There was no discussion in Patient 4's medical records regarding the increased amount of Suboxone for this visit. The drug screen results showed the patient was consistently positive for Suboxone and amphetamines with all other test results being negative. Additionally, Patient 4's CURES reports evidence the patient filling another prescription for Adderall from Respondent on April 19, 2016 for an additional 60 tablets. Again, there was no explanation provided in the patient's medical record as to this early refill.

83. According to a review of Patient 4's medical records and the CURES reports, from December 1, 2016 through April 7, 2017, Patient 4 filled prescriptions for 120 tablets of Alprazolam at 0.5 mg, and two stimulants: 169 tablets of methylphenidate at 20 mg, and 420 tablets of amphetamines at 20 mg from Respondent.

84. On or about May 1, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent prescribed Patient 4 120 tablets of Adderall at 30 mg and 90 tablets of Lexapro[8] at 10 mg. There was no mention in Patient's 4 medical records regarding the rationale for the additional prescription of Lexapro for this visit. On or about May 24, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for 30 tablets of Suboxone, 120 tablets of Adderall at 30 mg, reviewed Patient 4's CURES reports, and obtained a drug screen. There was no explanation provided in the patient's medical record as to this early refill of Adderall. On or about May 31, 2017, Patient 4 was seen by Respondent for a skin infection, at which time Respondent noted that Patient 4 was malnourished; however, on or about June 9, 2017, Respondent had a metabolic panel completed by Patient 4 that indicated a contrary result regarding Patient 4's protein levels.

85. On or about June 21, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent diagnosed the patient with opioid dependence in remission and proceeded to refill her prescriptions for 90 tablets of Lexapro at 20 mg, 30 tablets of Suboxone at 2-0.5 mg, and 120 tablets of Adderall at 30 mg. Respondent obtained a drug screen from Patient 4, and according to the medical record notes, discussed the risk and side effect of the medications with the patient.

86. On or about July 22, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for Suboxone, Adderall, and prescribed vitamin D at 50,000 units weekly without any recent lab work evidencing the patient's vitamin D levels or obtaining the patient's weight at this visit. No rationale was noted for the vitamin D prescription at this visit in Patient 4's medical records on this day. Respondent noted that he reviewed the patient's CURES report and ordered a drug screen.

[8] Lexapro (escitalopram) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Escitalopram affects chemicals in the brain that may be unbalanced in people with depression or anxiety.

87. According to a review of Patient 4's medical records and the CURES reports, from April 14, 2017 through August 23, 2017, Patient 4 filled prescriptions for 540 tablets of amphetamines at 30 mg from Respondent.

88. On or about September 14, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent noted in the patient's medical records that he discussed using Suboxone for opioid and heroin dependency with Patient 4. Respondent refilled Patient 4's prescriptions for Suboxone and Adderall, reviewed her CURES report, and obtained a drug screen for Patient 4. Additionally, Patient 4's CURES reports evidence the patient filling a prescription for Adderall from Respondent on August 24, 2017 for 120 tablets of Adderall at 30 mg and then again on September 15, 2017 for an additional 120 tablets. There was no explanation provided in the patient's medical record as to this early refill.

89. On or about October 11, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for Suboxone, Adderall, reviewed the patient's CURES report, and obtained a drug screen. Respondent noted that the patient suffered from iron deficiency anemia and expressed concern about malnutrition in previous visits; however, the patient's weight was not noted at this visit and lab results for Patient 4's complete blood count (CBC) and iron studies are normal.

90. On or about November 1, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent noted the patient's weight at 134 lbs. and refilled her prescriptions for Suboxone and Adderall. On or about November 27, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent noted the patient's weight at 133 lbs., with an elevated pulse at 104 beat per minute (bpm). Respondent refilled her prescriptions and noted in the medical records the identical plan as Patient 4's previous November 2017 visit. According to a review of Patient 4's medical records and the CURES reports for November 2017, Respondent decreased the patient's Adderall dosage from 120 mg daily to 30 mg daily without a rationale or explanation in the patient's medical records for this month. However, the CURES reports for Patient 4 also evidence the patient filling a prescription for Adderall from Respondent on November 27, 2017 for 120 tablets of Adderall at 30 mg and

then again on December 13, 2017 for an additional 52 tablets. There was no explanation provided in the patient's medical record as to this early refill.

91. On or about December 26, 2017, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for Suboxone and increased her Adderall daily dosage from 30 mg to 120 mg and noted that he planned on discussing decreasing her Adderall dosage next month even though she did not absorb the drug well due to her previous gastric bypass. Respondent also noted that he reviewed her CURES report and obtained a drug screen from Patient 4, which showed that Patient 4 was positive for buprenorphine and negative for amphetamines despite the patient filling Respondent's prescription for amphetamine salts on December 9, 2017.

92. On or about January 18, 2018, Patient 4 was seen by Respondent for a Suboxone follow-up, during which Respondent refilled Patient 4's prescriptions for Suboxone and Adderall, reviewed the patient's CURES report, and noted in the medical records the intention to decrease to 500 mcg daily without any indication as to what precisely the decrease was in reference to.

93. On or about February 7, 2018, Patient 4 was seen by Respondent for a Suboxone follow-up. Respondent noted that Patient 4 was done with Suboxone, had stopped using her Suboxone a few days prior, and was feeling fatigued. Respondent noted that the patient's pulse was 134 bpm with a blood pressure of 158/104; however, there was no indication in the patient's medical records of Respondent addressing her bpm and blood pressure levels at this visit. Respondent prescribed 20 mg of Ritalin twice a day to Patient 4 to increase her energy level, even though Respondent had prescribed 120 tablets of Adderall to Patient 4 at her last visit on or about January 18, 2018. Respondent also prescribed 15 tablets of Phentermine at 37.5 mg while noting her weight at 132 lbs., but without noting a rationale in the medical records for prescribing this to Patient 4 at this visit or why three different stimulant types were prescribed to the patient. On or about February 12, 2018, Patient 4 was seen by Respondent for a Suboxone follow-up, during which time Respondent noted that the patient had stopped taking Suboxone for 1.5 weeks and was still feeling tired. Respondent prescribed 14 tablets of Ritalin at 20 mg for a total of 80 mg daily with the stated rationale of Patient 4's poor absorption due to previous gastric bypass

surgery. On or about February 19, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up, during which time Respondent noted that the patient had difficulty absorbing extended release of Adderall but was completely detoxed from Suboxone. Respondent also noted that Patient 4's pulse rate was 93 bpm, her blood pressure was 153/90, and that the patient scored 0 on the PHQ-9. Respondent refilled Patient 4's Adderall 30 mg prescription and obtained a drug screen from the patient.

94. According to a review of Patient 4's medical records and the CURES reports, from August 24, 2017 through February 10, 2018, Patient 4 filled prescriptions for over 800 tablets of amphetamines at 30 mg, 7 tablets of methylphenidate at 20 mg, and 15 tablets of phentermine at 37.5 mg from Respondent.

95. According to a review of Patient 4's medical records and the CURES reports, Patient 4 filled prescriptions from Respondent within a three-day period for three different stimulants concurrently: 120 tablets of Adderall at 30 mg on January 23, 2018, 15 tablets of Phentermine at 37.5 mg on February 7, 2018, 7 tablets of Methylphenidate at 20 mg on February 8, 2018, and 5 tablets of Adderall at 30 mg on February 10, 2018.

96. On or about March 12, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up, during which time Patient 4 reported having an iron infusion a few days prior, and Respondent noted the patient's weight at 136 lbs. with a pulse rate of 90 bpm. Respondent refilled Patient 4's prescription for 120 tablet Adderall at 30 mg and obtained a drug screen from the patient. On or about April 11, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up, during which time Patient 4 reported increased weight gain due to increased appetite. Respondent noted the patient's weight at 145 lbs. and refilled her Adderall prescription but also prescribed 100 mg Topiramate[9] twice daily.

97. Respondent refilled Patient 4's Adderall prescription and also prescribed 90 tablets of Armour Thyroid[10] at 30 mg on May 9, 2018 without noting a rationale for the thyroid supplement

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[9] Topiramate is an anticonvulsant and nerve pain medication that can also treat and prevent seizures, migraine headaches, and can be used for weight loss treatment.

[10] Armour Thyroid is a prescription medicine used to treat the symptoms of low thyroid hormone (hypothyroidism).

prescription at this or the prior visit in Patient 4's medical records. On or about June 6, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up during which time Patient 4 reported no hypertension and Respondent noted an increase in the patient's weight to 148 lbs. On or about July 2, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up during which time Respondent noted Patient 4's weight at 149 lbs. and refilled her prescriptions for Adderall and Armour Thyroid, but increased the thyroid supplement prescription to 90 mg dosages without noting a rationale for this increase. On or about July 30, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up, during which time Respondent noted Patient 4's weight at 143 lbs. and refilled her prescriptions for Adderall.

98. On or about September 12, 2018, Patient 4 reported that on September 10, 2018 her purse containing her amphetamine prescriptions from Respondent were stolen. According to a review of Patient 4's medical records and the CURES reports, on September 5, 2018, September 15, 2018, and on September 18, 2018 the patient filled prescriptions for Adderall from the Respondent for 120 tablets at 30 mg on each date.

99. On or about November 14, 2018, Patient 4 was seen by Respondent for an ADD/ADHD follow-up during which time Respondent refilled the patient's Adderall prescription and noted her weight at 143 lbs. and pulse rate at 104 bpm. Under review of symptoms for this visit, there was an addendum dated May 22, 2019 and initialed T.D. stating "no change from previous notes. still has difficulty focus on task and therefore increases her anxiety." Under impression for this visit, there was another addendum dated May 22, 2019 and initialed T.D. stating "due to gastric bypass in 2006 she cannot absorb XR adderall and has to use IR adderall at 30 mg qid to control her distraction at work."

100. On or about May 10, 2019, Patient 4 was seen by Respondent for a complaint of a skin infection. Respondent refilled the patient's Adderall prescription and prescribed 30 tablets of Alprazolam at 1 mg without noting a rationale for this prescribed benzodiazepine. On or about May 29, 2019, Patient 4 was seen by Respondent for an ADD follow-up. Respondent noted the patient presented with more than six criteria for a diagnosis of ADD on the DSM-V,[11] and

[11] Diagnostic and Statistical Manual of Mental Disorders 5th Ed.

because she had gastric bypass surgery, the patient could not absorb medications as a normal individual and most medications would pass through her intestinal tract intact without being broken down. Respondent also noted that the patient required multiple iron infusion in the last two years for iron deficiency due to an inability to absorb iron. Respondent's treatment plan consisted of continuing the patient on her current dosage of Adderall.

101. According to a review of Patient 4's medical records and the CURES reports, from February 12, 2017 through April 19, 2019, Patient 4 filled prescriptions for 14 tablets of methylphenidate at 20 mg, 1920 tablets of amphetamines at 30 mg, and over 120 tablets of Alprazolam at 0.25 mg from Respondent.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

102. Respondent Tuan Anh Doan, M.D. has subjected his Physician's and Surgeon's Certificate No. G 77825 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients 1, 2, 3, and 4. The circumstances are set forth in paragraphs 28 through 101, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

103. Respondent's license is subject to disciplinary action because he committed gross negligence during the care and treatment of Patients 1, 2, 3, and 4 in the following distinct and separate ways:

a. By excessively prescribing amphetamines at a dose of 120 mg per day to Patient 1 placing the patient at an increased risk of anxiety, headaches, emotional lability, irritability and heart rhythm abnormalities;

b. By failing to perform and/or document performing an on-going assessment of Patent 1's progress toward any treatment goals and objectives;

c. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of controlled substances to Patient 1;

d. By failing to provide and/or document informed consent to Patient 1 regarding the long-term risks and side effects of Adderall use;

e. By failing to initially evaluate and/or document performing an initial evaluation of Patient 1 to establish a diagnosis of medical necessity prior to prescribing lorazepam, stimulants, and/or testosterone to Patient 1;

f. By failing to document Patient 1's medical records to show rationale for changing dosages, concerns with Patient 1's illicit drug use, and concerns with Patient 1's drug testing;

g. By failing to provide and/or document informed consent to Patient 2 regarding the long-term risks and side effects of testosterone therapy;

h. By failing to initially evaluate and/or document performing an initial evaluation of Patient 2 to establish a diagnosis of medical necessity prior to prescribing testosterone to Patient 2;

i. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of testosterone to Patient 2;

j. By failing to perform and/or document performing an on-going assessment of Patent 2's progress toward any treatment goals and objectives;

k. By failing to document Patient 2's medical records to show diagnosis, treatment rationales, and treatment outcomes for testosterone treatment and/or Tramadol treatment in Patient 2's medical record.

l. By continuously and repeatedly prescribing Patient 3 with chronic opioids for the majority of the care and treatment for her migraine headache pain without evidence to support the use of opioids for migraine headaches;

m. By failing to clearly demonstrate in Patient 3's medical records any discussion between Respondent and Patient 3 regarding the potential risks or side effects of long-term opioid use such as the risk of respiratory depression, motor impairment, cognitive impairment, and/or death;

n. By failing to discuss the findings with Patient 3, appropriately acting, and/or altering his treatment plan upon receipt of drug testing results when such drug screens evidenced inconsistent or illicit drug use results;

o. By failing to specify measurable goals and objectives used to evaluate the treatment progress of Patient 3 while on chronic opioid therapy; for instance, failing to indicate in Patient 3's chart notes any discernible improvement in pain, duration and/or number of headache free days;

p. By failing to adequately document treatment plans, rationale for treatment, or outcomes of treatment in Patient 3's medical records;

q. By excessively prescribing dosages of amphetamines without appropriate assessment of Patient 4;

r. By failing to properly assess Patient 4 to determine whether her ADHD symptoms were controlled prior to increasing her dosage levels of prescribed medications;

s. By failing to specify measurable goals and objectives used to evaluate the treatment progress and plan of Patient 4 while on amphetamines; for instance, failing to indicate in Patient 4's chart notes any improvement in social and professional functions, improvement of symptoms and/or lack of side effects;

t. By failing to adequately document discussions of treatment plans, potential risks of long-term opioid use, frequent benzodiazepine use, and combined opioid and benzodiazepine use with Patient 4;

u. By failing to adequately document treatment plans, rationale for treatment, or outcomes of treatment in Patient 4's medical records and chart notes; and

v. By failing to complete the assessment of Patient 4's history, symptoms, mental status, functioning and side effects prior to initiating controlled substances, amphetamine stimulants, or prior to dosage escalation or medication changes during the treatment period.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

104. Respondent Tuan Anh Doan, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 77825 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, and 4 as more particularly alleged in paragraphs

28 through 101, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

105. The instances of gross departures from the standard of care as set forth in paragraph 103, are incorporated by reference as if fully set forth herein and serve as repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

106. Respondent Tuan Anh Doan, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 77825 to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that he failed to maintain adequate and accurate medical records of Patients 1, 2, 3, and 4 as more particularly alleged in paragraphs 28 through 103, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

107. Respondent Tuan Anh Doan, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 77825 to disciplinary action under sections 2227 and 2234, as defined by section 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine as to his care and treatment of Patients 1, 2, 3, and 4.

108. The circumstances are set forth in paragraphs 28 through 103, and those paragraphs are incorporated by reference and re-alleged as if fully set forth herein.

109. At an interview with the HQIU Investigator on August 23, 2019, and by way of email correspondence on August 29, 2019, Respondent's Medical Assistant 1 stated that she was employed by Respondent at the Doan Family Medicine facility located in Rocklin, California from approximately 2017 through 2019. She also stated that during that time, Respondent practiced medicine independently of other physicians and was instructed by Respondent that if she ever answered a phone call at the office from the Medical Board and was asked if Respondent was practicing independently, she was to answer, "No." Medical Assistant 1 also stated that she

was present when Patient 2 came into Respondent's office in or about June 2019 and observed the swelling in Patient 2's lower legs.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

110. Respondent Tuan Anh Doan, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 77825 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he committed incompetence. The circumstances are set forth in paragraphs 28 through 109, and those paragraphs are incorporated by reference and re-alleged as if fully set forth herein.

111. On or about July 29, 2020, Respondent incorrectly stated that Evekeo was a brand name for naloxone when in fact it is a Schedule II stimulant.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws)

112. At all times after the effective date of the Medical Board's Decision in Case No. 800-2017-031593, Condition No. 6 stated:

"Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders."

113. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 6, referenced above, in that he failed to obey all laws, as more particularly alleged in paragraphs 28 through 110, which are hereby incorporated by reference as if fully set forth therein.

SECOND CAUSE TO REVOKE PROBATION

(Violation of Probation)

114. At all times after the effective date of the Medical Board's Decision in Case No. 800-2017-031593, Condition No. 12 stated:

"Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect,

the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final."

115. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 12, referenced above, in that he violated his probation terms and conditions, as more particularly alleged in paragraphs 28 through 113, which are hereby incorporated by reference as if fully set forth therein.

THIRD CAUSE TO REVOKE PROBATION

(Violation of the Solo Practice Prohibition)

116. At all times after the effective date of the Medical Board's Decision in Case No. 800-2017-031593, Condition No. 3 stated:

"Solo Practice Prohibition. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5)

calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established."

117. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 3, referenced above, in that he violated his probation terms and conditions, as more particularly alleged in paragraphs 28 through 111, which are hereby incorporated by reference as if fully set forth therein.

DISCIPLINARY CONSIDERATIONS

118. To determine the degree of discipline, if any, to be imposed on Respondent Tuan Anh Doan, M.D., Complainant alleges that on or about January 5, 2018, in a prior disciplinary action titled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case No. 800-2014-007305, Respondent's license was revoked, however; the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of two (2) years with certain terms and conditions for engaging in repeatedly negligent acts in his care and treatment of four (4) patients in violation of Section 2234, subdivision (c), of the Code, and for failing to maintain adequate and accurate records for the same four patients in violation of Section 2266 of the Code. That decision is now final and is incorporated by reference as if fully set forth herein.

119. To determine the degree of discipline, if any, to be imposed on Respondent Tuan Anh Doan, M.D., Complainant alleges that on or about November 30, 2018, in a prior disciplinary action titled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case No. 800-2017-031593, Respondent's license was revoked, however; the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of three (3) years with certain terms and conditions for engaging in gross negligence in his care and treatment of a patient in violation of Section 2234, subdivision (b), of

the Code; for engaging in repeated negligent acts in violation of Section 2234, subdivision (c), of the Code; and for failing to maintain adequate and accurate records for the same patient in violation of Section 2266 of the Code. That decision is now final and is incorporated by reference as if fully set forth herein.

PATIENT HARM

120. Respondent's license, if placed on probation for five years or more, is subject to Business and Professions Code section 2228.1 for inappropriate prescribing of controlled substances and causing harm in the following distinct ways:

a. By prescribing Adderall as described in paragraphs 28 through 39, and those paragraphs are incorporated by reference as if fully set forth herein, to Patient 1 in an excessive dosage which can predispose the patient for cardiac arrhythmias. Patient 1 was later hospitalized with atrial fibrillation; and

b. By prescribing testosterone as described in paragraphs 40 through 45, and those paragraphs are incorporated by reference as if fully set forth herein, to Patient 2, in an excessive dosage despite Patient 2 having normal lab results for testosterone. Patient 2 later suffered a series of heart attacks.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 77825, issued to Tuan Anh Doan, M.D.;

2. Revoking, suspending or denying approval of Tuan Anh Doan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Tuan Anh Doan, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Tuan Anh Doan, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to Section 2228.1 of the Code; and

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

DATED: AUG 19 2021

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

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EXHIBIT A

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

In the Matter of the Accusation Against:	)	
TUAN ANH DOAN, M.D.	)	Case No. 8002017031593
Physician's and Surgeon's Certificate No. G77825	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 30, 2018.

IT IS SO ORDERED: November 1, 2018.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **TUAN ANH DOAN, M.D.** 1230 Sunset Blvd, Ste. 400 Rocklin, CA 95765 Physician's and Surgeon's Certificate No. G 77825, Respondent.	Case No. 800-2017-031593 OAH No. 2018040451 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

2. Respondent Tuan Anh Doan, M.D. ("Respondent") is represented in this proceeding by attorney Dr. Bruce W. Ebert, Esq., LL.M., ABPP, whose address is:

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Dr. Bruce W. Ebert, Esq., LL.M., ABPP
Attorney at Law
3400 Douglas Blvd., Ste. 250
Roseville, CA 95661

3. On or about October 27, 1993, the Board issued Physician's and Surgeon's Certificate No. G 77825 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-031593, and will expire on March 31, 2019, unless renewed. On or about January 5, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case Number 800-2014-007305, Respondent's license was revoked with the revocation stayed and his license was placed on two years probation with terms and conditions.

JURISDICTION

4. Accusation No. 800-2017-031593 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 7, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031593 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031593. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2017-031593.

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

CONTINGENCY

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

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

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

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 77825 issued to Respondent Tuan Anh Doan, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions. Once adopted by the Board, the stipulated settlement contained in Accusation No. 800-2017-031593, will supersede the terms of probation in Decision and Order No. 800-2014-007305. All terms and conditions of probation in Decision and Order No. 800-2014-007305 have been incorporated into the stipulated settlement in Accusation No. 800-2017-031593. Upon the effective date of the Decision and Order in Accusation Case No. 800-2017-031593, and once the time to challenge the matter has run, the probationary terms contained in Decision and Order No. 800-2014-007305 will terminate.

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

2. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to

compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of practice, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter. If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement

monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

3. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician to secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

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

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

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

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

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

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

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business

and Professions Code section 2021(b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

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

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

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

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

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ACCEPTANCE

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

DATED: 8/24/2018

TUAN ANH DOAN, M.D.
Respondent

I have read and fully discussed with Respondent Tuan Anh Doan, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/24/2018

DR. BRUCE W. EBERT, ESQ., LL.M., ABPP
Attorney for Respondent

ENDORSEMENT

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

Dated: 8/24/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-031593

XAVIER BECERRA
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Supervising Deputy Attorney General
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 7 20 18
BY _____ ANALYST

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

In the Matter of the Accusation Against: **Tuan Anh Doan, M.D.** 1230 Sunset Blvd, Ste. 400 Rocklin, CA 95765 Physician's and Surgeon's Certificate No. G 77825, Respondent.	Case No. 800-2017-031593 ACCUSATION

Complainant alleges:

PARTIES

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

2. On or about October 27, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G 77825 to Tuan Anh Doan, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2019, unless renewed.

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

5. Section 2234 of the Code, states in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

6. Section 2266 of the Code states, in pertinent part:

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence during the care and treatment of Patient A[1] by failing to properly refer the patient to urology following an abnormal prostrate specific antigen ("PSA") test result. The circumstances are as follows:

8. Respondent first met and began treating Patient A in the late nineteen nineties. In 2004[2], Respondent began treating Patient A at Sutter Medical Group ("Sutter") as Patient A's primary care physician. On or about June 2, 2005, Respondent ordered a PSA test for Patient A, who at that point was a fifty-year-old male. The PSA test came back as 6.92 ng./ml. which according to Sutter's laboratory was an elevated reading. On August 30, 2006, Respondent saw Patient A in clinic and noted the elevated PSA result. The Respondent performed a rectal exam and found no abnormalities. Respondent did not provide Patient A with a referral for a consultation with a urologist.

9. Respondent saw Patient A in clinic on seven separate occasions between July 30, 2007, and January 6, 2010. On February 25, 2008, Respondent ordered a PSA test for Patient A. The PSA test came back as 7.81 ng./ml. which according to Sutter's laboratory was an elevated reading. While the elevated PSA level was mentioned in Patient A's medical records problem list for visits on October 7, 2009, and January 6, 2010, there is no other documentation that Respondent discussed the PSA level with the patient, and he did not provide Patient A with a referral for consultation with a urologist.

10. On January 31, 2011, Respondent saw Patient A for a routine physical. The problem list portion of Patient A's medical record mentioned elevated PSA. Respondent documented that he performed a prostate examination and no abnormalities were detected. There is no

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[1] Patient A will be fully identified during the discovery phase of the administrative proceeding. All identifying information has been removed from this pleading.

[2] Any mention of conduct occurring before August 24, 2012, is for informational purposes only. Conduct occurring before August 24, 2012, may be potentially barred by the Statute of Limitations pursuant to Business and Professions Code § 2330.5.

documentation that Respondent discussed Patient A's elevated PSA levels, and he did not provide Patient A with a referral for a consultation with a urologist. Respondent next saw Patient A on February 7, 2012. The February 7, 2012, progress note does not mention PSA levels and there is no documentation that PSA levels were discussed with Patient A.

11. On August 23, 2012, Respondent saw Patient A in clinic regarding follow-up after Patient A was hospitalized following a LE graft bypass. In the progress note, Respondent noted that Patient A has multiple medical conditions. In the body of the progress note, elevated PSA is listed under the Patient Active Problem List. In the progress note under plan, there is a mention of "PSA elevation seeing urology" and Respondent ordered a new PSA test. In reviewing the records, there is no evidence that Respondent had previously referred patient A to urology at any point between 2004 and 2012. On August 24, 2012, Patient A's PSA test came back and showed a level of 25.51 ng./ml.

12. On September 11, 2012, Respondent saw Patient A for follow-up regarding a toe amputation. The Patient Active Problem List noted an elevated PSA but there is no documentation that Respondent referred Patient A for a urology consultation and there is no evidence that Respondent performed a prostate examination. There is no evidence in the record that Respondent discussed the PSA result of 25.51 ng./ml. with Patient A or explained what the result could mean.

13. On November 19, 2012, February 11, 2013, May 13, 2013, August 19, 2013, and November 18, 2013, Respondent documented that he saw Patient A for follow-up regarding Patient A's diabetes. There is no mention of Respondent discussing the elevated PSA level of 25.51 ng./ml. with Patient A, nor documentation of a referral for a consultation with urology. Respondent did not perform a prostate examination or order a new PSA test at any of these five appointments.

14. On November 27, 2013, Respondent documented a progress note that he went over diabetes labs with Patient A. There is no documentation that PSA levels were discussed. On February 18, 2014, Respondent documented that Patient A was present for a pre-operation visit and persistent cough. The progress note documented that PSA levels were a problem area. There

was no mention of a prostate examination, no mention of a referral to urology, and no mention that the elevated PSA levels were discussed with the patient. On May 21, 2014, Respondent saw Patient A regarding follow-up with diabetes. The problem list of the progress note documented elevated PSA levels. There is no documentation that Respondent performed a prostate examination, ordered new PSA testing, discussed the PSA levels with Patient A, or referred Patient A for a consultation with a urologist.

15. On August 25, 2014; Patient A established primary care services with a new provider at Sutter. Patient A's new primary care physician documented that Patient A's PSA levels were elevated and ordered a new PSA test. The new primary care physician documented that if the new test revealed a high PSA level that he would refer Patient A for a urology consultation. On September 15, 2014, the PSA test revealed a level of 27.40 ng./ml. Based on that result, Patient A's new primary care physician referred him for a consultation with urology. On December 22, 2014, Patient A underwent a radical prostatectomy after being diagnosed with prostate cancer.

16. On September 27, 2017, pursuant to an investigational subpoena, the Respondent attended a subject interview with the Board. Respondent acknowledged during the interview that Patient A had "probably not," seen urology when he documented that the patient had seen urology on the August 23, 2012 visit. Respondent acknowledged that he made an "oversight" and that Patient A was not seeing a urologist despite three PSA tests above 4 ng./ml. Respondent stated that he did not notify the patient of his PSA level at the November 2012 treatment visit despite having received notification that the PSA test was above 25 ng./ml. Respondent stated that it was his responsibility to ensure that Patient A saw a urologist but stated that this was one of over a hundred similar patients.

17. Respondent's treatment of Patient A as described above represents an extreme departure from the standard of care by failing to immediately refer Patient A for a urology consultation after receiving a 25.51 ng./ml. PSA test result.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent Tuan Anh Doan, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the care and treatment of Patient A. The circumstances are as follows:

19. Complainant re-alleges paragraphs 7 through 17, and those paragraphs are incorporated by reference as if fully set forth herein.

20. Respondent's license is subject to disciplinary action because he committed the following repeated negligent acts during the care of Patient A:

a.) As more fully described in paragraphs 12 through 15, by failing to communicate three abnormal PSA test results from June 2005, March 2008, and August 2012, and discuss the PSA test results with the patient at any treatment visits and/or document discussing the three abnormal PSA test results with the patient between September 11, 2012, to May 21, 2014, in any of the progress notes in 9 outpatient clinic visits represents multiple and repeated separate departures from the standard of care.

b.) As more fully described in paragraphs 12 through 15, by failing to diagnose possible prostate cancer at an earlier state despite three abnormal PSA test results from June 2005, March 2008, and August 2012, at any treatment visits and/or document diagnosing possible prostate cancer at an earlier stage between September 11, 2012, to May 21, 2014, in any of the progress notes in 9 outpatient clinic visits represents multiple and repeated separate departures from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping)

21. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records. The circumstances are as follows:

22. Complainant re-alleges paragraphs 7 through 20, and those paragraphs are incorporated by reference as if fully set forth herein.

23. A review of the medical records from August 23, 2012, to May 21, 2014, reveals no documentation regarding Respondent's treatment plan and/or discussion with the patient regarding three abnormal PSA levels from June 2005, March 2008, and August 2012.

DISCIPLINARY CONSIDERATIONS

24. To determine the degree of discipline, if any, to be imposed on Respondent Tuan Anh Doan, M.D., Complainant alleges that on or about January 5, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case Number 800-2014-007305, Respondent's license was revoked with the revocation stayed and his license was placed on two years' probation for the commission of repeated negligent acts in violation of Section 2234, subdivision (c), of the Code and inadequate record keeping in violation of Section 2266. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 77825, issued to Tuan Anh Doan, M.D.;

2. Revoking, suspending or denying approval of Tuan Anh Doan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Tuan Anh Doan, 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: March 7, 2018

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

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EXHIBIT A

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

In the Matter of the Accusation Against:	)	
TUAN ANH DOAN, M.D.	)	Case No. 8002017031593
Physician's and Surgeon's Certificate No. G77825	)	
Respondent	)	

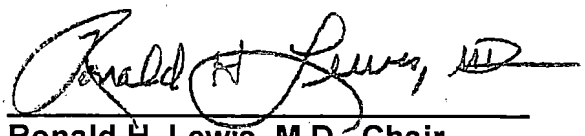
DECISION

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

This Decision shall become effective at 5:00 p.m. on November 30, 2018.

IT IS SO ORDERED: November 1, 2018.

MEDICAL BOARD OF CALIFORNIA



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

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JOHN S. GATSCHET
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California Department of Justice
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Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **TUAN ANH DOAN, M.D.** 1230 Sunset Blvd, Ste. 400 Rocklin, CA 95765 Physician's and Surgeon's Certificate No. G 77825, Respondent.	Case No. 800-2017-031593 OAH No. 2018040451 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

2. Respondent Tuan Anh Doan, M.D. ("Respondent") is represented in this proceeding by attorney Dr. Bruce W. Ebert, Esq., LL.M., ABPP, whose address is:

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Dr. Bruce W. Ebert, Esq., LL.M., ABPP
Attorney at Law
3400 Douglas Blvd., Ste. 250
Roseville, CA 95661

3. On or about October 27, 1993, the Board issued Physician's and Surgeon's Certificate No. G 77825 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-031593, and will expire on March 31, 2019, unless renewed. On or about January 5, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case Number 800-2014-007305, Respondent's license was revoked with the revocation stayed and his license was placed on two years probation with terms and conditions.

JURISDICTION

4. Accusation No. 800-2017-031593 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 7, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031593 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031593. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2017-031593.

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

CONTINGENCY

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

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

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

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 77825 issued to Respondent Tuan Anh Doan, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions. Once adopted by the Board, the stipulated settlement contained in Accusation No. 800-2017-031593, will supersede the terms of probation in Decision and Order No. 800-2014-007305. All terms and conditions of probation in Decision and Order No. 800-2014-007305 have been incorporated into the stipulated settlement in Accusation No. 800-2017-031593. Upon the effective date of the Decision and Order in Accusation Case No. 800-2017-031593, and once the time to challenge the matter has run, the probationary terms contained in Decision and Order No. 800-2014-007305 will terminate.

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

2. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to

compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of practice, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter. If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement

monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

3. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician to secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

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

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

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

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

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

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

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business

and Professions Code section 2021(b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

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

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

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

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

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ACCEPTANCE

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

DATED: 8/24/2018

TUAN ANH DOAN, M.D.
Respondent

I have read and fully discussed with Respondent Tuan Anh Doan, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/24/2018

DR. BRUCE W. EBERT, ESQ., LL.M., ABPP
Attorney for Respondent

ENDORSEMENT

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

Dated: 8/24/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-031593

XAVIER BECERRA
Attorney General of California
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Supervising Deputy Attorney General
JOHN S. GATSCHET
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Facsimile: (916) 327-2247

Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 7 20 18
BY ANALYST

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

In the Matter of the Accusation Against: **Tuan Anh Doan, M.D.** 1230 Sunset Blvd, Ste. 400 Rocklin, CA 95765 Physician's and Surgeon's Certificate No. G 77825, Respondent.	Case No. 800-2017-031593 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 27, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G 77825 to Tuan Anh Doan, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2019, unless renewed.

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

5. Section 2234 of the Code, states in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

6. Section 2266 of the Code states, in pertinent part:

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence during the care and treatment of Patient A[1] by failing to properly refer the patient to urology following an abnormal prostrate specific antigen ("PSA") test result. The circumstances are as follows:

8. Respondent first met and began treating Patient A in the late nineteen nineties. In 2004[2], Respondent began treating Patient A at Sutter Medical Group ("Sutter") as Patient A's primary care physician. On or about June 2, 2005, Respondent ordered a PSA test for Patient A, who at that point was a fifty-year-old male. The PSA test came back as 6.92 ng./ml. which according to Sutter's laboratory was an elevated reading. On August 30, 2006, Respondent saw Patient A in clinic and noted the elevated PSA result. The Respondent performed a rectal exam and found no abnormalities. Respondent did not provide Patient A with a referral for a consultation with a urologist.

9. Respondent saw Patient A in clinic on seven separate occasions between July 30, 2007, and January 6, 2010. On February 25, 2008, Respondent ordered a PSA test for Patient A. The PSA test came back as 7.81 ng./ml. which according to Sutter's laboratory was an elevated reading. While the elevated PSA level was mentioned in Patient A's medical records problem list for visits on October 7, 2009, and January 6, 2010, there is no other documentation that Respondent discussed the PSA level with the patient, and he did not provide Patient A with a referral for consultation with a urologist.

10. On January 31, 2011, Respondent saw Patient A for a routine physical. The problem list portion of Patient A's medical record mentioned elevated PSA. Respondent documented that he performed a prostate examination and no abnormalities were detected. There is no

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[1] Patient A will be fully identified during the discovery phase of the administrative proceeding. All identifying information has been removed from this pleading.

[2] Any mention of conduct occurring before August 24, 2012, is for informational purposes only. Conduct occurring before August 24, 2012, may be potentially barred by the Statute of Limitations pursuant to Business and Professions Code § 2330.5.

documentation that Respondent discussed Patient A's elevated PSA levels, and he did not provide Patient A with a referral for a consultation with a urologist. Respondent next saw Patient A on February 7, 2012. The February 7, 2012, progress note does not mention PSA levels and there is no documentation that PSA levels were discussed with Patient A.

11. On August 23, 2012, Respondent saw Patient A in clinic regarding follow-up after Patient A was hospitalized following a LE graft bypass. In the progress note, Respondent noted that Patient A has multiple medical conditions. In the body of the progress note, elevated PSA is listed under the Patient Active Problem List. In the progress note under plan, there is a mention of "PSA elevation seeing urology" and Respondent ordered a new PSA test. In reviewing the records, there is no evidence that Respondent had previously referred patient A to urology at any point between 2004 and 2012. On August 24, 2012, Patient A's PSA test came back and showed a level of 25.51 ng./ml.

12. On September 11, 2012, Respondent saw Patient A for follow-up regarding a toe amputation. The Patient Active Problem List noted an elevated PSA but there is no documentation that Respondent referred Patient A for a urology consultation and there is no evidence that Respondent performed a prostate examination. There is no evidence in the record that Respondent discussed the PSA result of 25.51 ng./ml. with Patient A or explained what the result could mean.

13. On November 19, 2012, February 11, 2013, May 13, 2013, August 19, 2013, and November 18, 2013, Respondent documented that he saw Patient A for follow-up regarding Patient A's diabetes. There is no mention of Respondent discussing the elevated PSA level of 25.51 ng./ml. with Patient A, nor documentation of a referral for a consultation with urology. Respondent did not perform a prostate examination or order a new PSA test at any of these five appointments.

14. On November 27, 2013, Respondent documented a progress note that he went over diabetes labs with Patient A. There is no documentation that PSA levels were discussed. On February 18, 2014, Respondent documented that Patient A was present for a pre-operation visit and persistent cough. The progress note documented that PSA levels were a problem area. There

was no mention of a prostate examination, no mention of a referral to urology, and no mention that the elevated PSA levels were discussed with the patient. On May 21, 2014, Respondent saw Patient A regarding follow-up with diabetes. The problem list of the progress note documented elevated PSA levels. There is no documentation that Respondent performed a prostate examination, ordered new PSA testing, discussed the PSA levels with Patient A, or referred Patient A for a consultation with a urologist.

15. On August 25, 2014; Patient A established primary care services with a new provider at Sutter. Patient A's new primary care physician documented that Patient A's PSA levels were elevated and ordered a new PSA test. The new primary care physician documented that if the new test revealed a high PSA level that he would refer Patient A for a urology consultation. On September 15, 2014, the PSA test revealed a level of 27.40 ng./ml. Based on that result, Patient A's new primary care physician referred him for a consultation with urology. On December 22, 2014, Patient A underwent a radical prostatectomy after being diagnosed with prostate cancer.

16. On September 27, 2017, pursuant to an investigational subpoena, the Respondent attended a subject interview with the Board. Respondent acknowledged during the interview that Patient A had "probably not," seen urology when he documented that the patient had seen urology on the August 23, 2012 visit. Respondent acknowledged that he made an "oversight" and that Patient A was not seeing a urologist despite three PSA tests above 4 ng./ml. Respondent stated that he did not notify the patient of his PSA level at the November 2012 treatment visit despite having received notification that the PSA test was above 25 ng./ml. Respondent stated that it was his responsibility to ensure that Patient A saw a urologist but stated that this was one of over a hundred similar patients.

17. Respondent's treatment of Patient A as described above represents an extreme departure from the standard of care by failing to immediately refer Patient A for a urology consultation after receiving a 25.51 ng./ml. PSA test result.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent Tuan Anh Doan, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the care and treatment of Patient A. The circumstances are as follows:

19. Complainant re-alleges paragraphs 7 through 17, and those paragraphs are incorporated by reference as if fully set forth herein.

20. Respondent's license is subject to disciplinary action because he committed the following repeated negligent acts during the care of Patient A:

a.) As more fully described in paragraphs 12 through 15, by failing to communicate three abnormal PSA test results from June 2005, March 2008, and August 2012, and discuss the PSA test results with the patient at any treatment visits and/or document discussing the three abnormal PSA test results with the patient between September 11, 2012, to May 21, 2014, in any of the progress notes in 9 outpatient clinic visits represents multiple and repeated separate departures from the standard of care.

b.) As more fully described in paragraphs 12 through 15, by failing to diagnose possible prostate cancer at an earlier state despite three abnormal PSA test results from June 2005, March 2008, and August 2012, at any treatment visits and/or document diagnosing possible prostate cancer at an earlier stage between September 11, 2012, to May 21, 2014, in any of the progress notes in 9 outpatient clinic visits represents multiple and repeated separate departures from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping)

21. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records. The circumstances are as follows:

22. Complainant re-alleges paragraphs 7 through 20, and those paragraphs are incorporated by reference as if fully set forth herein.

23. A review of the medical records from August 23, 2012, to May 21, 2014, reveals no documentation regarding Respondent's treatment plan and/or discussion with the patient regarding three abnormal PSA levels from June 2005, March 2008, and August 2012.

DISCIPLINARY CONSIDERATIONS

24. To determine the degree of discipline, if any, to be imposed on Respondent Tuan Anh Doan, M.D., Complainant alleges that on or about January 5, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Tuan Anh Doan, M.D.* before the Medical Board of California, in Case Number 800-2014-007305, Respondent's license was revoked with the revocation stayed and his license was placed on two years' probation for the commission of repeated negligent acts in violation of Section 2234, subdivision (c), of the Code and inadequate record keeping in violation of Section 2266. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 77825, issued to Tuan Anh Doan, M.D.;

2. Revoking, suspending or denying approval of Tuan Anh Doan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Tuan Anh Doan, 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: March 7, 2018

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

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