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

In the Matter of the First Amended Accusation Against: Rahima Afghan, M.D. Physician's and Surgeon's Certificate No. A 67257 Respondent.	Case No. 800-2018-049085

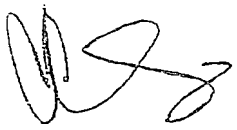
DECISION

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 January 12, 2023.

IT IS SO ORDERED: December 13, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation Against: RAHIMA AFGHAN, M.D. 770 Magnolia Avenue, Suite 1F Corona, California 92879 Physician's and Surgeon's Certificate No. A 67257 Respondent.	Case No. 800-2018-049085 OAH No. 2022010392 **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 Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Rahima Afghan, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, CA 92620.

3. On January 1, 1999, the Board issued Physician's and Surgeon's Certificate No. A 67257 to Rahima Afghan, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-049085, and will expire on January 31, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-049085 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on or about June 23, 2022. Respondent timely filed her Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2018-049085 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-049085. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2018-049085, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2018-049085, a true and correct copy of which is attached hereto as Exhibit A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 67257 to disciplinary action.

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

CONTINGENCY

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

14. Respondent agrees that if she ever petitions for early termination or modification of probation, or if a First Amended Accusation and/or petition to revoke probation is filed against

her before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2018-049085 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 67257 issued to Respondent Rahima Afghan, 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:

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

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

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

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

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

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

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

effective date of this Decision.

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

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

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

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

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 First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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 First Amended Accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $ 8,000 (eight thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs (if applicable).

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. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. 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 a First Amended 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.

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 First Amended Accusation No. 800-2018-049085 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. 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: 8/30/22

RAHIMA AFGHAN, M.D.
Respondent

I have read and fully discussed with Respondent Rahima Afghan, 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: August 30, 2022

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

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

DATED: August 31, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the First Amended Accsuation Against: **Rahima Afghan, M.D.** **770 Magnolia Avenue, Suite 1F** **Corona, CA 92879** **Phsyician's and Surgeon's Certificate No. A 67257,** Respondent.	Case No. 800-2018-049085 OAH Case No. 2022010392 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about January 1, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number A 67257 to Rahima Afghan, 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 January 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

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

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. 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.

COST RECOVERY

7. Effective on January 1, 2022, section 125.3 of the Code provides:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may

reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.
(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.[1]

DEFINITIONS

8. Alprazolam, sold under the brand name Xanax, is a benzodiazepine depressant used to treat anxiety. Alprazolam is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 11057, subdivision (d)(1).

9. Clonazepam, sold under the brand name Klonopin, is a benzodiazepine depressant used to treat anxiety and seizures. It is a dangerous drug pursuant to Business and Professions

[1] Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians and surgeons from seeking recovery of the costs of investigation and prosecution by the Board, was repealed.

Code section 4022 and a scheduled IV controlled substance pursuant to Health and Safety Code section 11507, subdivision (d)(7).

10. Oxycodone is an opioid narcotic used for relief of moderate to severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

11. Butran patch, also known under the trade name Butrans Patch is an extended release transdermal system that contains the opioid analgesic buprenorphine, and comes in various strengths to treat pain. Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022 and a Schedule V controlled substance pursuant to Health and Safety Code section 11508, subdivision (d).

12. Fentanyl transdermal patch is a transdermal system that contains the opioid analgesic fentanyl, and is used to treat severe pain. Fentanyl, is an opiate, and a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (c)(8).

13. Tylenol #3 is a combination medication that contains acetaminophen and codeine and is used to treat moderate to severe pain. Tylenol #3 is an opiate, and a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule III controlled substance pursuant Health and Safety Code section 11055, subdivision (c)(8).

FACTUAL ALLEGATIONS

14. On or about August 31, 2015, after an extensive review of the latest scientific evidence, the U.S. Food and Drug Administration announced that it is requiring class-wide changes to drug labeling, including patient information, to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines. Among the changes, the FDA required boxed warnings and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these

medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and death.

15. Starting on or about October 2, 2018, Health and Safety Code section 11165.4. (a) (1) (A) (i) requires a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance, to consult the CURES database[2] to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time, and at least once every four months thereafter, if the substance remains part of the treatment of the patient.

Patient 1[3]

16. Respondent began treatment of Patient 1 at the Orange Psychiatric Medical Clinic on or about March 30, 2017, taking over Patient 1's care from another provider. Patient 1's prior provider documented on January 5, 2017, that Patient 1 appeared in distress and in pain, and he noted that she had undergone a previous kidney transplant and suffered from arthritis that caused her knee and neck pain, and that she was taking Percocet. Respondent's assessment of Patient 1 was that she was suffering from a major depressive disorder, and Respondent documented that she reviewed the prior psychiatrist's notes and that Patient 1 appeared anxious and depressed. The bulk of Respondent's chart entries in this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 1's psychological symptoms and did not elicit and document Patient 1's orientation and memory or consideration of any cognitive impairment. On March 30, 2017, Respondent adjusted other psychotropic medications, and continued Patient 1 on the Xanax (alprazolam) regimen established by the previous psychiatrist: .5 mg, to take three a day. Respondent continued this alprazolam regimen through approximately July 12, 2018, at which time alprazolam was reduced to .25 mg, to take three a

[2] CURES stands for Controlled Substance utilization Review and Evaluation System, a prescription drug monitoring program established pursuant to Health and Safety Code section 11165 et seq.

[3] Patients are known to Respondent. They are designated by number for privacy reasons. Their names will be provided to Respondent upon a written Request for Discovery.

day. This regimen continued until approximately October 4, 2018, when Respondent reduced Patient 1's alprazolam .25 mg from three a day to one daily. This continued until approximately January 18, 2019, when Respondent switched Patient 1 from alprazolam to long-acting clonazepam 1 mg daily. Starting approximately on October 10, 2019, Respondent reduced clonazepam to .5 mg daily. This regimen was continued monthly, though January 15, 2020.

17. Simultaneously with Respondent's alprazolam and clonazepam regimen, Patient 1 was also receiving prescriptions for opioid pain medications from other physicians outside of the Orange Psychiatric Medical Clinic. In the three weeks prior to Patient 1's first encounter with Respondent, on or about March 30, 2017, she received a large quantity of high dose oxycodone HCL and acetaminophen 325/10 mg #120 (Percocet), to be taken 4 times per day, as well as the opioid Butran patch (buprenorphine transdermal). Through January 1, 2018, Patient 1 received Percocet and Butran every month from physicians other than Respondent. In February 2018, Butran was discontinued and Patient 1 was prescribed a fentanyl transdermal patch, plus Percocet 325/10 mg 4 times per day, by physicians other than Respondent. As of February, 2018 and continuing through October 10, 2019, Respondent prescribed clonazepam 1 mg daily to Patient 1, and .5 mg daily after October 10, 2019, while she was receiving both fentanyl and Percocet.

18. Respondent's clinical record for Patient 1 makes no mention of the preexisting opioid prescription during that first March 30, 2017 visit. Respondent failed to obtain and/or document a sufficient history from Patient 1, as she failed to elicit and record information about Patient 1's use of opioids for pain for many months. In the notes of the November 2, 2017 encounter, respondent noted that Patient 1 had surgery for esophageal cancer, but there is no elaboration about Patient 1's clinical status, her ability to swallow, her pain levels, or whether Patient 1 used pain medication. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 1's memory or cognition or testing of same. Facility records show that "CURES REPORT was "approved" on July 18, 2018, November 1, 2018, and June 19, 2019, though Respondent made no mention of CURES reports in any of her notes.

19. As of approximately January 18, 2019, Respondent was aware that Patient 1 was using pain medication, as she noted her intention to "stop Xanax add Klonopin [clonazepam] and told her [Patient 1] not to take pain meds at night." On or about March 15, 2019, Respondent once again documented that she "[t]old her [Patient 1] again not to take her pain meds at night." Respondent did not document her reasoning for advising Patient 1 not to take her pain medication at night, whether it was feasible to instruct Patient 1 not to take her pain medications at night, when she was using a long-acting transdermal patch and taking Percocet 4 times a day. Respondent did not contact the doctors who prescribed pain medication in order to coordinate Patient 1's care, and did not document any attempt to make such contacts.

20. On or about June 14, 2019, Respondent noted " ... and next visit will start tapering her [Patient 1] from Klonopin [clonazepam] ... " However, when Patient 1 saw Respondent on or about July 9, 2019, and on August 13, 2019, Respondent continued to prescribe clonazepam at 1 mg daily, without an attempt to taper it. Respondent failed to obtain and/or document Patient 1's informed consent for prescribing of benzodiazepines, especially in light of concomitant dosing of this patient with opioids.

21. During the visit of October 10, 2019, Respondent noted that "Patient is taking a lot of pain meds will up the Effexor lower the Klonopin goal is to finally stop Klonopin." Respondent did not document which pain medicines or how much, Patient 1 was taking. Respondent reduced Patient 1's clonazepam from 1 mg daily to .5 mg daily.

22. Respondent's next visit with Patient 1 was on or about December 10, 2019. Respondent did not mention any prescription for clonazepam in the note for that visit, yet Patient 1 filled Respondent's prescription for clonazepam .5 mg #30 at a pharmacy on December 15, 2019.

23. Respondent's next visit with Patient 1 was on or about January 9, 2020. Respondent did not document any further effort to reduce Patient 1's clonazepam, and a pharmacy dispensed 30 tablets of clonazepam .5 mg, a months' supply, to her, on January 15, 2020.

24. Respondent saw Patient 1 on or about February 6, 2020. In that note Respondent charted that Patient 1 was "... sleeping better without taking Klonopin [clonazepam]."

Patient 2

25. Respondent began treatment of Patient 2, a 54-year-old woman, at the Orange Psychiatric Medical Clinic on or about August 25, 2015. The patient transitioned to Respondent's care from another provider. Respondent noted that Patient 2 "stated doing okay." Respondent documented an assessment of "DEPRESSION, MAJOR, RECURRENT, MODERATE EPISODE (improving)." Respondent noted that she reviewed the prior provider's chart and noted recent medication changes. Respondent also noted that Patient 2 was taking Klonopin 1 mg. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 2's psychological symptoms and did not elicit and document Patient 2's orientation and memory or consideration of any cognitive impairment. At her first visit with Patient 2, on August 25, 2015, Respondent prescribed clonazepam, 1 mg daily.

26. On the next visit, on or about September 22, 2015, Respondent noted that Patient 2 "stated doing well meds are helping denied any depressive symptoms." Respondent also noted that Patient 2 had been taking Klonopin 1 mg tablet at bedtime. On the next visit with Patient 2, on or about November 17, 2015, Respondent noted that she was changing Patient 2's Klonopin regimen; that note indicated that Klonopin 1 mg at bed time "stopped – other – changing." Respondent failed, however, to indicate what change was being made. During the next visit, on or about February 9, 2016, Respondent continued to note that Patient 2 was prescribed Klonopin 1 mg at bedtime. This prescription for clonazepam was renewed at every visit with Patient 2, until February 28, 2017.

27. During the visit with Respondent on December 16, 2016, Respondent wrote: "Pt stated doing okay meds are helping told her will continue with current and she should bring me copy of her labs next year." Respondent did not elaborate what labs she was interested in and for what reason.

28. On the next visit with Patient 2, on or about February 28, 2017, Respondent again documented that "Patient 2 stated doing well no problems." Respondent, however, continued to provide clonazepam to Patient 2. She changed the prescription from 1 mg "1.00 as directed" to .5 mg, "1.00 as directed." Respondent did not elaborate or document in her treatment record precisely what her directions regarding clonazepam were, or why the change was made. However, on March 1, 2017, Patient 2 was dispensed 63 tablets of clonazepam, .5 mg, at a pharmacy, with instructions that she take clonazepam 3 times per day over a 21-day period.

29. Respondent provided 1,071 pills of .5 mg clonazepam over 488 days[4] to Patient 2, who filled prescriptions for 63 tablets of clonazepam, .5 mg, on the following dates: March 1, 2017; April 12, 2017; May 16, 2017; June 4, 2017; August 7, 2017; September 7, 2017; October 13, 2017; October 29, 2017; November 13, 2017; December 11, 2017; January 15, 2018; January 30, 2018; March 30, 2018; April 18, 2018; May 7, 2018; May 26, 2018; June 13, 2018; July 2, 2018; August 28, 2018.

30. During Respondent's visit with Patient 2 on or about August 15, 2017, Respondent noted that "Pt stated emotionally doing well but physically she is in pain." Respondent did not elaborate on the patient's pain complaints and despite those complaints, noted that the patient "is in no distress." Patient 2's medications, including clonazepam, were renewed without changes by Respondent. Respondent saw Patient 2 regularly through April 24, 2021, and her clonazepam was refilled consistently until she was dispensed 63 tablets of .5 mg clonazepam by a pharmacy on August 28, 2018.

31. Patient 2 returned to see Respondent on November 13, 2018. Respondent noted that Patient 2 " stated feeling pretty good no problems. Went to Romania her mother in law was sick. Her insurance covers only 21 days each month." On that date it has been 77 days since August 28, 2018, when Patient 2 was dispensed 63 tablets of .5mg clonazepam. Respondent did not document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2 after a

[4] There are 488 days between March 1, 2017 and July 2, 2018. During that period, not including on July 2, 2018, Patient 2 was dispensed 63 tablets of .5 mg clonazepam 17 times.

pause, when Patient 2 stated that she was feeling "pretty good." Patient 2 was dispensed 63 clonazepam .5 mg tablets on November 13, 2018.

32. Patient 2 returned to see Respondent on February 5, 2019, 84 days later. Respondent noted that Patient 2 was "feeling pretty good no complaints." Patient 2 was dispensed 63 clonazepam .5 mg tablets on February 5, 2019. Respondent did not document, or elaborate in any way, why she continued prescribing clonazepam to Patient 2, when Patient 2 stated that she was feeling "pretty good" and "had no complaints." Patient 2 was dispensed 63 clonazepam .5 mg tablets on February 5, 2019, and 42 tablets of clonazepam .5 mg on May 2, 2019, May 23, 2019, June 19, 2019, July 9, 2019, July 29, 2019, and August 6, 2019.

33. Patient 2 returned to see Respondent on or about August 20, 2019. Respondent noted that "Pt stated feeling pretty good no problems. Pt is taking pain meds so I will start tapering her from Klonopin." When Patient 2 returned to see Respondent on November 12, 2019, Respondent noted that "pt is taking pain meds will lower the Klonopin again. Respondent did not elaborate what "pain meds" the patient was taking, or the manner in which she was planning to lower the Klonopin. Even though Respondent acknowledged that Patient 2 was taking "pain meds" Respondent continued to prescribe clonazepam .5 mg, for Patient 2 to take "as directed," with no information documented about what instructions were given, and no information about what "pain meds" were recorded in the patient's chart. Respondent's intent to lower the patient's Klonopin indicates that Respondent was or should have been aware that Patient 2 was taking opioid pain medications, but no informed consent for prescribing benzodiazepines and concomitant dosing with opioids was ever given or recorded. On August 30, 2019, the patient was dispensed 18 tablets of .5 mg clonazepam; 32 tablets of .5 mg clonazepam on September 12, 2019, October 3, 2019, October 24, 2019, and November 18, 2019; 7 tablets on December 14, 2019, 21 tablets on December 20, 2019, January 8, 2020, February 16, 2020, March 7, 2020, and March 27, 2020.

34. While Respondent was prescribing clonazepam to Patient 2, as described above, Patient 2 was consistently prescribed 60 OxyContin 15 mg and 90 Percocet 325/10 mg, per month by another physician. Respondent failed to obtain and/or document a sufficient history from

Patient 2, as she failed to elicit and record any pertinent information about Patient 2's use of opioids, and prescribed the benzodiazepine clonazepam to Patient 2 concomitantly with opiates. In the patient's chart on August 15, 2017, Respondent noted that Patient 2 was in pain and in her notes of the August 20 and November 12, 2019 Respondent noted that Patient 2 was taking "pain meds" but no where in her records for Patient 2 is there any elaboration about why Patient 2 was in pain, what and/or how much pain medication Patient 2 was taking, or her pain level. No consideration of concomitant prescribing of opiate and benzodiazepine medications is discussed; no informed consent for this combination of medications is discussed or documented. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 2's memory or cognition or perform testing of same. Facility records show that "CURES REPORT was "approved" on November 14, 2018, April 30, 2019 and August 20, 2019, though Respondent made no mention of CURES reports in any of her notes.

Patient 3

35. Patient 3, a 51-year-old woman at the time, was seen by another psychiatrist at Orange Psychiatric Medical Clinic for the first time on February 19, 2016. Patient 3 had been suffering from anxiety for three years, and was being prescribed Xanax (alprazolam) by her primary care physician. The prior provider at Orange Psychiatric Medical Clinic did not document how long Patient 3 was taking Xanax, whether she was taking any other medication, or if she had any other health problems. Patient 3 was assessed with generalized anxiety. Respondent took over the care of Patient 3, on or about March 16, 2016. Respondent did not document how long Patient 3 had been taking Xanax previously, whether she was taking any other medication, or if she had any other health problems. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 3's psychological symptoms and did not elicit and

document Patient 3's orientation and memory or consideration of any cognitive impairment. On the March 16, 2016 visit, and continuing for more than three years, through September 19, 2019, Respondent prescribed alprazolam, 2 mg at bedtime, to Patient 3. Respondent did not obtain and/or document obtaining informed consent for long-term treatment with alprazolam, or for concomitant prescribing of alprazolam with opioid medications. At the first visit Respondent recorded that the patient " ... takes her Xanax 2 mg only at night. That helps not want to change her meds or take any antidepressant."

36. Concomitantly with alprazolam, at least between March 13, 2017 through September 18, 2020, Patient 3 was also receiving from several pharmacies, the opiate pain medication Norco. In addition to Norco, Patient 3 was dispensed Tylenol #3 (acetaminophen with codeine) on October 13, 2017, October 24, 2017, and May 8, 2018.

37. Respondent was aware that Patient 3 was taking opiate pain medications and that she should not take those concomitantly with Xanax. In the chart note of July 18, 2018, Respondent noted that Patient 3 "takes Norco for pain told her she can not mix that with Xanax pt stated she takes Norco in the morning and takes Xanax at night." At the March 16, 2018 session Respondent documented that Patient 3 "was in a car accident 3 weeks ago ... " No details of the circumstances of that accident were obtained or documented. Respondent did not note any injuries or any exacerbation of Patient 3's pain. In fact, Respondent never elicited or recorded any description of Patient 3's pain, or any other reason Patient 3 was taking opiate medications at the same time Respondent was prescribing her a benzodiazepine. Respondent never discussed or recorded Patient 3's opioid dosing, and never obtained and/or documented informed consent for long-term benzodiazepine treatment, or concomitant use of opioid medications and benzodiazepines. On March 9, 2019, Respondent once again documented that Patient 3 "takes her Norco only in the morning does not take it at night when she takes the Xanax." Respondent also noted that Patient 3 suffered a bout of pneumonia, though once again, she elicited and recorded no details about a potential respiratory compromise of a patient who was concomitantly taking opiate and benzodiazepine medications. On June 8, 2019, Respondent again "... told her not to take it ant night." (Sic.) At no time during the course of her care that included a prolonged

use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 3's memory or cognition or perform testing of same.

38. Patient 3's chart contains a chart update dated July 5, 2018, which states that Patient 3's CURES was "printed." A chart update dated June 6, 2019, states, inaccurately, that "CURES checked [Respondent] is the only prescriber." Respondent never acknowledged these chart updates in any of her notes. Respondent did not access CURES herself to review Patient 3's prescribing history.

Patient 4

39. Respondent began to treat Patient 4, a 53-year old woman, on March 7, 2017, at the Orange Psychiatric Medical Clinic. Respondent took over Patient 4's care from another provider. The bulk of Respondent's chart entries into this patient's medical record appeared to be "copy and pasted" from prior entries and contained minimum clinical information. Respondent never ordered laboratory testing nor obtained and documented current laboratory test results from other clinicians to rule out any possible physiological causes for Patient 4's psychological symptoms and did not elicit and document Patient 4's orientation and memory or consideration of any cognitive impairment. Patient 4 was assessed as suffering from bipolar disorder and, at a later date, Respondent added an assessment of agoraphobia with panic disorder.

40. Starting on March 7, 2017, Respondent prescribed clonazepam 1 mg three times a day to Patient 4. This dose was lowered to 2 tablets of 1 mg clonazepam daily, as of approximately November 13, 2018. Starting on or about August 21, 2020, patient 4 was dispensed 1.5 tablets of clonazepam per day per Respondent's prescription, and starting on or about December 18, 2019, Respondent began to prescribe her 1 tablet of 1 mg clonazepam per day.

41. During this period, other physicians prescribed opioids to treat Patient 4's pain, that overlapped Respondent's prescriptions of clonazepam. Tramadol 50 mg twice per day was dispensed to Patient 4 on September 15, 2017, and the dose was increased significantly on October 20, 2017, but Respondent continued clonazepam without change, prescribing 90 tablets

(3 daily) of 1 mg clonazepam. Respondent noted that Patient 4 appeared depressed during this period, but made no further inquiry and did not comment about the patient's pain.

42. A total of 306 tablets of Percocet 5/325 were dispensed to Patient 4 between March and May, 2019. Despite the overlapping prescriptions of opioids, Respondent did not alter the amount of clonazepam she was prescribing to Patient 4, continuing to prescribe 2 tablets of 1 mg of clonazepam per day. The May 24, 2019, prescription of 40 tablets of Percoet was followed by Respondent prescribing clonazepam 1 mg (two a day) 60 tablets on June 13, 2019.

43. On April 26, 2019, Respondent noted that Patient 4 "stated feeling good no problems. Had knee replacement surgery 7 weeks ago." In Patient 4's chart note on June 20, 2019, Respondent noted that Patient 4 "stated feeling good no problems. Pt is still taking pain meds even now that she had knee replacement surgery so told her will start tapering her from Klonopin and told her in the mean time until she will be off Klonopin she should take pain meds with Klonopin at the same time should take them at least 4 hours apart." Respondent failed to obtain and/or document Patient 4's informed consent to use benzodiazepine medication long term, and/or to use it concomitantly with opioids. Respondent failed to consider and/or make any entries into Patient 4's medical record explaining why Respondent continued to prescribe clonazepam to Patient 4 despite being aware of the concomitant prescriptions of opioids to Patient 4. At no time during the course of her care that included a prolonged use of benzodiazepines together with opiates, which was or should have been known to Respondent, did Respondent elicit and/or document any information about Patient 4's memory or cognition or test for same.

44. Patient 4's chart contains notations that Patient 4's CURES report was "OK" or "APPROVED" on January 8, 2019, June 25, 2019, August 16, 2019 and January 28, 2020, though Respondent made no mention of CURES reports in any of her notes.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

45. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code in that she was grossly negligent in her care and treatment of four patients. The circumstances are as follows:

46. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

47. The following acts and omissions by Respondent, taken together or separately represent gross negligence:

A) Respondent's manner of prescribing clonazepam to Patient 1, while Patient 1 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

B) Respondent's manner of prescribing clonazepam to Patient 2, while Patient 2 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

C) Respondent's manner of prescribing alprazolam to Patient 3, while Patient 3 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

D) Respondent's manner of prescribing clonazepam to Patient 4, while Patient 4 was simultaneously receiving opioid medications from other physician or physicians, is an extreme departure from the standard of care.

E) Respondent's failure to utilize CURES in her care and treatment of Patient 1 is an extreme departure from the standard of care.

F) Respondent's failure to utilize CURES in her care and treatment of Patient 2 is an extreme departure from the standard of care.

G) Respondent's failure to utilize CURES in her care and treatment of Patient 3 is an extreme departure from the standard of care.

H) Respondent's failure to utilize CURES in her care and treatment of Patient 4 is an extreme departure from the standard of care.

I) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 1 is an extreme departure from the standard of care.

J) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 2 is an extreme departure from the standard of care.

K) Respondent's dosing and/or long-term prescribing of alprazolam to Patient 3 is an extreme departure from standard of care.

L) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 4 is an extreme departure from the standard of care.

M) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations of Patient 1 is an extreme departure from the standard of care.

N) Respondent's failure to perform and/or document appropriate intake examinationand follow up examinations, including initial and follow up laboratory testing, of Patient 2 is an extreme departure from the standard of care.

O) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 3 is an extreme departure from the standard of care.

P) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 4 is an extreme departure from the standard of care.

Q) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 1 in the manner that she did is an extreme departure from the standard of care.

R) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 2 in the manner that she did is an extreme departure from the standard of care.

S) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 3 in the manner that she did is an extreme departure from the standard of care.

T) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 4 in the manner that she did is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent Rahima Afghan, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that she committed repeated negligent acts in the care and treatment of four patients. The circumstances are as follows:

49. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

50. Each of the following is a departure from the standard of care.

A) Respondent's manner of prescribing clonazepam to Patient 1, while Patient 1 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

B) Respondent's manner of prescribing clonazepam to Patient 2, while Patient 2 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

C) Respondent's manner of prescribing alprazolam to Patient 3, while Patient 3 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

D) Respondent's manner of prescribing clonazepam to Patient 4, while Patient 4 was simultaneously receiving opioid medications from other physician or physicians, is a departure from the standard of care.

E) Respondent's failure to utilize CURES in her care and treatment of Patient 1 is a departure from the standard of care.

F) Respondent's failure to utilize CURES in her care and treatment of Patient 2 is a departure from the standard of care.

G) Respondent's failure to utilize CURES in her care and treatment of Patient 3 is a departure from the standard of care.

H) Respondent's failure to utilize CURES in her care and treatment of Patient 4 is a departure from the standard of care.

I) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 1 is a departure from the standard of care.

J) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 2 is a departure from the standard of care.

K) Respondent's dosing and/or long-term prescribing of alprazolam to Patient 3 is a departure from standard of care.

L) Respondent's dosing and/or long-term prescribing of clonazepam to Patient 4 is a departure from the standard of care.

M) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 1 is a departure from the standard of care.

N) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 2 is a departure from the standard of care.

O) Respondent's failure to perform and/or document appropriate intake examination, including initial and follow up laboratory testing, and follow up examinations of Patient 3 is a departure from the standard of care.

P) Respondent's failure to perform and/or document appropriate intake examination and follow up examinations, including initial and follow up laboratory testing, of Patient 4 is a departure from the standard of care.

Q) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 1 in the manner that she did is a departure from the standard of care.

R) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 2 in the manner that she did is a departure from the standard of care.

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S) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 3 in the manner that she did is a departure from the standard of care.

T) Respondent's failure to obtain and/or document informed consent for prescribing of benzodiazepine medications to Patient 4 in the manner that she did is a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

51. Respondent Rahima Afghan, M.D. is subject to disciplinary action under Code section 2266 in that Respondent failed to keep adequate and accurate records of the care she rendered to four patients. The circumstances are as follows:

52. The allegations of paragraphs 14 through 44 are incorporated herein by reference.

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 A 67257, issued to Rahima Afghan, M.D.;

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

3. Ordering Respondent Rahima Afghan, M.D. to pay the Board reasonable costs of investigation and prosecution incurred after January 1, 2022.

4. Ordering Rahima Afghan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 05 2022

Reji Varghese
Deputy Director

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

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