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

In the Matter of the Third Amended Accusation Against: James Anthony Novak, M.D. Physician's and Surgeon's Certificate No. G 44909 Respondent.	Case No.: 800-2018-044421

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 February 24, 2023.

IT IS SO ORDERED: January 27, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D. , Chair
Panel B

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
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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 Third Amended Accusation Against: **JAMES ANTHONY NOVAK, M.D.** **4440 Lamont Street** **San Diego, California 92109** **Physician's and Surgeon's Certificate No. G 44909,** Respondent.	Case No. 800-2018-044421 OAH No. 2021100842 **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, and by Joseph F. McKenna III, Deputy Attorney General.

2. Respondent James Anthony Novak, M.D. (Respondent) is represented in this proceeding by attorney Paul J. Pfingst, Esq., whose address is: 401 W "A" Street, Suite 2600, San Diego, California, 92101.

3. On or about June 25, 1981, the Board issued Physician's and Surgeon's Certificate No. G 44909 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Third Amended Accusation No. 800-2018-044421, and will expire on September 30, 2024, unless renewed.

JURISDICTION

4. On May 24, 2021, Accusation No. 800-2018-044421 was filed before the Board. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on May 24, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. On November 5, 2021, First Amended Accusation No. 800-2018-044421 was filed before the Board. A true and correct copy of the First Amended Accusation and all other statutorily required documents were properly served on Respondent on November 5, 2021.

6. On February 4, 2022, Second Amended Accusation No. 800-2018-044421 was filed before the Board. A true and correct copy of the Second Amended Accusation and all other statutorily required documents were properly served on Respondent on February 4, 2022.

7. On May 25, 2022, Third Amended Accusation No. 800-2018-044421 was filed before the Board, and is currently pending against Respondent. A true and correct copy of the Third Amended Accusation and all other statutorily required documents were properly served on Respondent on May 25, 2022.

8. A copy of Third Amended Accusation No. 800-2018-044421 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

9. Respondent has carefully read, discussed with his counsel, and fully understands the charges and allegations contained in Third Amended Accusation No. 800-2018-044421. Respondent has also carefully read, discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

10. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations contained in the Third Amended Accusation; the right to

confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws, having been fully advised of same by his counsel.

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

CULPABILITY

12. Respondent understands and agrees that the charges and allegations contained in Third Amended Accusation No. 800-2018-044421, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. G 44909.

13. Respondent stipulates that, at a hearing, Complainant could establish a *prima facie* case or factual basis for the charges and allegations contained in the Third Amended Accusation; that he gives up his right to contest those charges and allegations contained in the Third Amended Accusation; and that he has thereby subjected his Physician's and Surgeon's Certificate to disciplinary action.

CONTINGENCY

14. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board 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.

15. Respondent agrees that if an accusation is ever filed against him before the Board, all of the charges and allegations contained in Third Amended Accusation No. 800-2018-044421

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.

ADDITIONAL PROVISIONS

16. 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.

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. 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 44909 issued to Respondent James Anthony Novak, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for 7 years from the effective date of the Decision on the following terms and conditions.

1. EDUCATION COURSE.

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

2. PRESCRIBING PRACTICES COURSE.

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than 12 months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within 1 year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges contained in Third Amended Accusation No. 800-2018-044421, 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 12 months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within 1 year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges contained in Third Amended Accusation No. 800-2018-044421, 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 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 12 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 1 year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges contained in the Third Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board, be accepted towards the fulfillment of this condition if the program would have been approved by the Board 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 course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM.

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board. Respondent shall successfully complete the program not later than 6 months after Respondent's initial enrollment unless the Board agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the 6 general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision and Disciplinary Order, the Third Amended Accusation, and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within 3 calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

6. MONITORING – PRACTICE.

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's medical practice at his own offices 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 to cease the practice of medicine within 3 calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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The monitor shall submit a quarterly written report to the Board 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. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board 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 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.

7. 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 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 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 to cease the practice of medicine within 3 calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

8. PROHIBITED PRACTICE.

During probation, Respondent is prohibited from issuing any type of immunization exemption(s) to any patient. During probation, Respondent is prohibited from performing any care or treatment of patients involving the use of insulin infusion therapy ("Trina Therapy").

After the effective date of this Decision, Respondent shall notify all patients requesting immunization exemptions or insulin infusion therapy from Respondent that he is prohibited from issuing immunization exemption(s) or performing any care or treatment involving insulin infusion therapy. Any new patients requesting immunization exemptions or insulin infusion therapy from Respondent must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board, and shall retain the log for the entire term of probation.

9. NOTIFICATION.

Within 7 days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and the Third 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.

10. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES.

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. OBEY ALL LAWS.

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

12. ENFORCEMENT COST RECOVERY.

Respondent is hereby ordered to reimburse the Board its costs of enforcement, including legal review and expert review, as applicable, in the amount of thirty-five thousand one hundred seventy three dollars and seventy-five cents ($35,173.75). 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, including expert review costs (if applicable).

13. 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.

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14. 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 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.

15. 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.

16. NON-PRACTICE WHILE ON PROBATION.

Respondent shall notify the Board 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 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' 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 2 years.

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

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

17. COMPLETION OF PROBATION.

Respondent shall comply with all financial obligations (e.g., probation costs and enforcement cost recovery) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

18. 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.

19. LICENSE SURRENDER.

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

20. 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.

21. 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 Third Amended Accusation No. 800-2018-044421 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, Paul J. Pfingst, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/21/2022

JAMES ANTHONY NOVAK, M.D.
Respondent

I have read and fully discussed with Respondent James Anthony Novak, 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: _____

PAUL J. PFINGST, 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: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Paul J. Pfingst, Esq. I fully 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: _____

JAMES ANTHONY NOVAK, M.D.
Respondent

I have read and fully discussed with Respondent James Anthony Novak, 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: November 21, 2022

PAUL J. PFINGST, 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: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Paul J. Pfingst, Esq. I fully 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: _____

JAMES ANTHONY NOVAK, M.D.
Respondent

I have read and fully discussed with Respondent James Anthony Novak, 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: _____

PAUL J. PFINGST, 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: NOVEMBER 22, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Third Amended Accusation No. 800-2018-044421

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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 Third Amended Accusation Against: **JAMES ANTHONY NOVAK, M.D.** **4440 Lamont Street** **San Diego, California 92109** **Physician's and Surgeon's Certificate No. G 44909,** Respondent.	Case No. 800-2018-044421 OAH No. 2021100842 **THIRD AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about June 25, 1981, the Board issued Physician's and Surgeon's Certificate No. G 44909 to James Anthony Novak, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on September 30, 2022, unless renewed.

JURISDICTION

3. This Third Amended Accusation which supersedes Second Amended Accusation No. 800-2018-044421, filed on February 4, 2022, in the above-entitled matter, 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.

STATUTORY PROVISIONS

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, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have 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.
>
> (d) Incompetence.
>
> ...

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

7. Section 2266 of the Code states:

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

COST RECOVERY

8. Section 125.3 of the Code states:

(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 licentiate 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.

PERTINENT DRUG INFORMATION

9. Opioids are Schedule II controlled substances pursuant to Health and Safety Code section 11055, and are a dangerous drug pursuant to Code section 4022. The Drug Enforcement Administration (DEA) has identified opioids as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at pp. 38-39.)

10. Adderall is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, and a dangerous drug pursuant to Code section 4022. Adderall contains 2 drugs (amphetamine and dextroamphetamine) and it belongs to a class of medications called stimulants. When properly prescribed and indicated, Adderall is most commonly used to treat attention deficit hyperactivity disorder (ADHD).

11. Suboxone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, and a dangerous drug pursuant to Code section 4022. Suboxone contains a combination of buprenorphine (opioid partial agonist) and naloxone (opiate antagonist). Buprenorphine is an opioid medication. Naloxone blocks the effects of opioid medication, including pain relief or feelings of well-being that can lead to opioid abuse. Suboxone is specifically intended for use as a treatment for opioid use disorder (OUD), which is a problematic pattern of opioid use that leads to serious impairment or distress.

12. Benzodiazepines are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, and are a dangerous drug pursuant to Code section 4022. The risk of respiratory depression, drug overdose, and death is increased with the concomitant prescribing of benzodiazepines with opioids, muscle relaxants (Soma), and sedatives (Ambien). The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

13. Soma (brand name for carisoprodol) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Code section 4022. Soma is a skeletal muscle relaxant. When properly prescribed and indicated, Soma is used for the short-term treatment of acute and painful musculoskeletal conditions. Soma is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high."

The risk of respiratory depression, synergistic sedation, and death is increased with the concomitant prescribing of Soma with Suboxone and Ambien.

14. Ambien (brand name for zolpidem) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, Ambien is used for the short-term treatment of insomnia, typically 2 to 3 weeks. If treatment of insomnia with Ambien extends beyond this initial period, regular follow-up by the treating physician is recommended to assess for efficacy, possible side-effects and harms, as well as to evaluate other treatment approaches including other medication classes. Ambien has central nervous system (CNS) depressant effects and its use can potentially worsen symptoms of depression and suicidal thoughts in patients suffering from depression. The use of Ambien is associated with increased incidence of completed suicide. It should be prescribed with caution in patients suspected of having depression or suicidal thoughts, and in the lowest effective dose.

15. Methocarbamol is a prescription medication and is a dangerous drug pursuant to Code section 4022. Methocarbamol is a muscle relaxant and CNS depressant, and it interacts with opioids, benzodiazepines, and Soma, causing additive CNS and respiratory suppression. When properly prescribed and indicated, Methocarbamol is used to relieve the discomfort caused by acute (short-term), painful muscle or bone conditions.

16. Baclofen is a prescription medication and is a dangerous drug pursuant to Code section 4022. Baclofen is a muscle relaxant and CNS depressant, and it has additive adverse CNS effects with opioids, benzodiazepines, and other muscle relaxants. When properly prescribed and indicated, Baclofen is used to treat muscle spasms caused by certain medical conditions.

17. Naltrexone is a prescription medication and is a dangerous drug pursuant to Code section 4022. Naltrexone belongs to a group of drugs known as opioid antagonists, which block the effects of heroin and other opioid drugs. When properly prescribed and indicated, Naltrexone is used to treat OUD and alcohol use disorder.

18. Hydroxyzine is a prescription medication and is a dangerous drug pursuant to Code section 4022. Hydroxyzine is an antihistamine, and it interacts with both opioids and

benzodiazepines, with additive respiratory and CNS suppression. When properly prescribed and indicated, Hydroxyzine is used to treat itching caused by allergies.

19. Selegiline is a prescription medication and is a dangerous drug pursuant to Code section 4022. Selegiline is a selective monoamine oxidase (MAO) type B inhibitor, which presents risks of multiple serious and potentially lethal drug-drug interactions. When properly prescribed and indicated, Selegiline is used to treat symptoms of Parkinson's disease.

20. For a comparison of opioid doses, "morphine milligram equivalents" was developed to equate the many different opioids into one standard value. This standard value is based on morphine and its potency. "Morphine milligram equivalents" is commonly referred to as MME. The Centers for Disease Control and Prevention states, "Higher dosages of opioids are associated with higher risk of overdose and death – even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk."

21. The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

22. Polypharmacy means the use of several medications on a daily basis. The more drugs, the higher the risk of adverse drug interactions and unintentional overdose. Polypharmacy exposes older adults to an increased risk of adverse drug interactions, drug toxicity, falls with injury, delirium and nonadherence. Polypharmacy increases the risk of adverse reactions to medications.

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PERTINENT CASE INFORMATION

23. Respondent, at all times relevant to the charges and allegations brought in Third Amended Accusation No. 800-2018-044421, owned Novak Medical Group (NMG), a clinic where he also employed and supervised Family Nurse Practitioner P.F. (FNP P.F.).

24. On or about January 22, 2020, Respondent, with his attorney present, was interviewed by a Division of Investigation (DOI) investigator and a district medical consultant (DMC) working on behalf of the Board. During the interview, Respondent answered a number of general background questions, including questions about medical providers working at NMG whom he supervised, which are relevant to the charges and allegations brought in Third Amended Accusation No. 800-2018-044421. During the interview, Respondent stated that FNP P.F. had worked for him for approximately twenty-one years. Respondent admitted to having a "Scope of Practices" agreement with FNP P.F., and that it was signed by them both. At all times relevant to the charges and allegations brought in Third Amended Accusation No. 800-2018-044421, Respondent was the supervising physician of FNP P.F. During the interview, Respondent also answered specific questions regarding the care and treatment involving Patients D and E and Trina Therapy.[1]

25. Trina therapy is advertised as resolving complications for people with diabetes through use of pulses of intravenous insulin administered by a pump, and delivered via catheter into the patient. The weekly therapy is performed in outpatient settings and lasts 4 hours at each visit.

26. On or about April 6, 2021, Respondent, with his attorney present, was telephonically interviewed by a DOI investigator and a DMC working on behalf of the Board. During the interview, Respondent answered a number of general background questions which are relevant to the charges and allegations brought in Third Amended Accusation No. 800-2018-044421. During the interview, Respondent answered specific questions regarding the care and treatment involving Patient C.[2]

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[1] To protect the privacy of the patients involved in this matter, patient names have not been included in this pleading. Respondent is aware of the identities of Patients D and E.

[2] Respondent is aware of the identity of Patient C.

27. On or about June 17, 2021, Respondent, with his attorney present, was telephonically interviewed by a DOI investigator and a DMC working on behalf of the Board. During the interview, Respondent answered a number of general background questions which are relevant to the charges and allegations brought in Third Amended Accusation No. 800-2018-044421. During the interview, Respondent answered specific questions regarding the care and treatment involving Patients A and B.[3]

28. On or about July 28, 2021, Respondent, with his attorney present, was telephonically interviewed by a DOI investigator and answered a number of follow-up questions regarding prescription pads and the care and treatment involving Patients A and B.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent has subjected his Physician's and Surgeon's Certificate No. G 44909 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed acts of gross negligence in his care and treatment of Patients A, B, and C, and he also committed acts of gross negligence by failing to properly supervise FNP P.F. in her care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

30. **Patient A**

(a) From in or around January 2016, to in or around August 2021, Patient A treated with Respondent and FNP P.F. at NMG. During that timeframe, Respondent and FNP P.F. saw Patient A for a number of chronic medical issues including, opioid dependence under treatment with Suboxone, chronic pain, chronic fatigue, muscle spasm, insomnia, and gastroesophageal reflux disorder. During that same timeframe, Respondent and FNP P.F. routinely issued prescriptions for controlled substances to Patient A including, but not limited to, Suboxone, Soma, Ambien, and Adderall.

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[3] Respondent is aware of the identities of Patient A and B.

(b) On or about January 6, 2016, Patient A, a then-55-year-old male, presents at NMG for medication refills. Under history of present illness (HPI) in the progress note, Patient A's chronic pain is described as "stable" on Suboxone and his addictive behavior is "under control." Under current medications, the progress note lists Soma, Ambien, and Suboxone.

(c) On or about March 14, 2016, Patient A returns to NMG for a follow-up visit. HPI is word-for-word identical to progress notes from prior visits in 2016. Although Suboxone is missing under current medications, the prescription is refilled at this visit, along with Soma and Ambien.

(d) On or about June 8, 2016, Patient A returns to NMG for medication refills. The general examination is word-for-word identical to progress notes from prior visits in 2016. And again, HPI is word-for-word identical to progress notes from prior visits in 2016. Suboxone is again missing under current medications, but the prescription is refilled at this visit. The prescriptions for Soma and Ambien are also refilled at this visit.

(e) On or about December 20, 2016, Patient A returns to NMG for a follow-up visit. The general examination remains word-for-word identical to progress notes from prior visits in 2016. Suboxone remains missing under current medications, but the drug prescription is refilled similar to prior visits in 2016.

(f) In or around 2016, Respondent and FNP P.F. charted approximately 12 clinical visits with Patient A at NMG. Significantly, at each visit Patient A received concomitant prescriptions for Suboxone, Soma, and Ambien.

(g) On or about January 19, 2017, Patient A returns to NMG for medication refills. The current medications for Patient A are the same as in 2016, including Suboxone, Soma, and Ambien.

(h) On or about August 23, 2017, Patient A returns to NMG for a follow-up visit. The general examination is word-for-word identical to progress notes from prior visits in 2017, with minor alterations to HPI. The current medications remain

essentially the same for Patient A, except that the progress note indicates Suboxone was to be taken "three times daily," but only 60 tablets are prescribed by Respondent. Respondent does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit.

(i) On or about September 21, 2017, Patient A returns to NMG for a follow-up visit. The progress note indicates Soma is discontinued under current medications, but it is still prescribed by Respondent to Patient A at this visit. Similar to the prior month's visit, the Suboxone prescription is to be taken "three times daily," but only 60 tablets are prescribed by Respondent. Again, Respondent does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit.

(j) On or about October 19, 2017, Patient A returns to NMG for a follow-up visit. The Suboxone prescription is lowered to 1.5 tablets daily (#45) but Respondent does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit.

(k) On or about December 20, 2017, Patient A returns to NMG for medication refills. The Suboxone prescription is lowered again (#30) but Respondent does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit.

(l) In or around 2017, Respondent and FNP P.F. charted approximately 13 clinical visits with Patient A at NMG. Significantly, at each visit Patient A received concomitant prescriptions for Suboxone, Soma, and Ambien. The Suboxone prescription was changed at multiple visits in 2017, with no detailed documentation of the rationale for changing the quantity of Suboxone.

(m) On or about January 18, 2018, Patient A returns to NMG for a follow-up visit. The Suboxone prescription is increased to 1.5 tablets daily (#45), but Respondent does not document in detail in the progress note the rationale for changing the quantity of Suboxone at this visit. The current medications remain mostly unchanged.

(n) On or about May 10, 2018, Patient A returns to NMG for a follow-up visit. The Suboxone prescription is lowered to 30 tablets a month at this visit, but Respondent does not document in detail in the progress note the rationale for changing the quantity of Suboxone. The general examination is word-for-word identical to progress notes from prior visits in 2017.

(o) On or about August 1, 2018, Patient A returns to NMG for a follow-up visit. Patient A is "now down to 30 [Suboxone] a month," according to the progress note for the visit. Respondent increases the Suboxone prescription to 1.5 tablets daily (#45), but he does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit. The current medications remain mostly unchanged.

(p) On or about November 19, 2018, Patient A returns to NMG for a follow-up visit. Respondent increases the Suboxone prescription to 2 tablets daily (#60), but he does not document in detail in the progress note the rationale for changing the quantity of Suboxone at this visit. The current medications remain mostly unchanged.

(q) In or around 2018, Respondent and FNP P.F. charted approximately 17 clinical visits with Patient A at NMG. Significantly, at each visit Patient A received concomitant prescriptions for Suboxone, Soma, and Ambien. The Suboxone prescription was changed at multiple visits in 2018, with no detailed documentation in the progress notes of the rationale for changing the quantity of Suboxone. Regarding Patient A's Ambien and Soma prescriptions listed under current medications, several progress notes indicated "Not-Taking/PRN" for the drugs; but according to CURES, Patient A consistently filled both of those prescriptions in 2018. The general examination language contained in progress notes are mostly identical in 2018.

(r) On or about January 17, 2019, Patient A returns to NMG for medication refills. Respondent again lowers the Suboxone prescription to 1.5 tablets daily (#45) and continues to concomitantly prescribe Soma and Ambien to Patient A.

(s) On or about April 10, 2019, Patient A returns to NMG for a follow-up visit. Respondent doubles the Suboxone prescription to 3 tablets daily (#90), but he does not document in detail in the progress note the rationale for changing the quantity of Suboxone at this visit.

(t) On or about July 10, 2019, Patient A returns to NMG for medication refills. According to the progress note for the visit, the dose of Suboxone is listed as 1.5 tablets per day (#45); however, different daily amounts of Suboxone (#30 and #60) are also documented in the same note.

(u) On or about September 24, 2019, Patient A returns to NMG for medication refills. Respondent increases the Suboxone prescription to 2 tablets daily (#60), but he does not document in detail in the note the rationale for changing the quantity of Suboxone at this visit.

(v) Progress notes from visits to NMG in November and December of 2019 document that Patient A stated he wants to stop taking Suboxone and treat his pain naturally. The notes further indicate that Patient A would start decreasing the number of Suboxone tablets taken per month, according to a "decreasing dosage prescription written by [Respondent]."

(w) In or around 2019, Respondent and FNP P.F. charted approximately 13 clinical visits with Patient A at NMG. Significantly, at each visit Patient A received concomitant prescriptions for Suboxone, Soma, and Ambien. The Suboxone prescription was changed at multiple visits in 2019, with no detailed documentation in the progress notes of the rationale for changing the quantity of Suboxone. The HPI and general examination language contained in the notes are mostly identical in 2019.

(x) On or about January 28, 2020, Patient A returns to NMG for a follow-up visit. Patient A is "tapered off" of Suboxone and "agreed to no further Suboxone" treatment, according to the progress note for the visit. There is no further documentation in the note regarding a plan for tapering of the drug after years of

use by Patient A. There is also no documentation regarding the large supply of Suboxone recently obtained by Patient A from prescriptions issued by Respondent.[4] At this visit, Respondent diagnoses Patient A with ADHD and prescribes a 1-month trial of Adderall (stimulant) to address complaints of fatigue, and lack of concentration and focus. The note does not document any discussion regarding whether a taper of other sedatives taken by Patient A (i.e., Suboxone, Soma, and Ambien) would address the symptoms of inattention.

(y) On or about February 25, 2020, Patient A returns to NMG for a follow-up visit. According to the progress note for the visit, Patient A is "doing well off of suboxone. denies cravings. bp stable. adhd much improved with adderall. thyroid is stable." There is no documentation of Suboxone being prescribed at this visit.[5] However, on or about March 4, 2020, Patient A fills a prescription issued by Respondent for Suboxone 2mg-0.5mg (#90), according to CURES.

(z) On or about April 2, 2020, Patient A returns to NMG for a follow-up visit. According to the progress note, "add well controlled with adderall. needs refill of suboxone." Respondent issues a prescription for Suboxone #60 (2mg-0.5mg) to Patient A. Significantly, Respondent does not document in the note the rationale for resuming the use of Suboxone with Patient A after allegedly "tapering off" the drug only two months earlier.

(aa) On or about June 16, 2020, Patient A returns to NMG for a follow-up visit. According to the progress note, "needs refill of suboxone/adhd meds. stable. still grieving for death of daughter." Respondent documents a psychiatric examination of Patient A in the note for this visit. Respondent doubles the Adderall prescription to #60 tablets, and he also continues to refill prescriptions of Suboxone, Soma, and Ambien.

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[4] According to CURES, on or about January 22, 2020, Patient A filled two separate Suboxone prescriptions totaling #360 tablets (2mg/0.5mg).

[5] Suboxone 8-2 mg tablet is the dosage strength listed under current medications in the progress note.

(bb) On or about September 15, 2020, Patient A returns to NMG for a follow-up visit. No drug prescriptions are documented in the progress note for this visit. However, CURES shows Patient A filled his usual prescriptions issued by Respondent that same month.

(cc) In or around 2020, Respondent charted approximately 11 clinical visits with Patient A at NMG. Significantly, Respondent issued concomitant prescriptions for Suboxone, Soma, Ambien, and Adderall to Patient A at nearly every office visit in 2020. The progress notes do not document the rationale for prescribing Adderall rather than first attempting a taper of Suboxone, Soma, and Ambien. Despite routine prescriptions of Adderall issued by Respondent, Adderall is not listed under current medications in any of the progress notes in 2020. In 2020, Respondent issued near monthly prescriptions of Suboxone (2mg-0.5mg) in varying quantities to Patient A, according to CURES. However, there is no detailed documentation in the notes of the rationale for changing the quantity of Suboxone from visit to visit. In addition, Suboxone 8-2 mg tablet is the dosage strength listed under current medications in the progress notes in 2020, which is significantly different from the prescribing data shown in CURES in 2020. The HPI and general/psychiatric examination language contained in many of the progress notes are mostly identical in 2020.

(dd) On or about January 5, 2021, Patient A returns to NMG for a follow-up visit. Respondent documents performing a psychiatric examination of Patient A at this visit. The psychiatric examination documented at this visit contains the exact same language used in 7 prior progress notes, which allegedly document psychiatric examinations performed by Respondent at each visit. Respondent issues prescriptions for Suboxone, Soma, Ambien, and Adderall to Patient A at this visit.

(ee) On or about February 2, 2021, Patient A returns to NMG for a follow-up visit. Patient A's Ambien prescription is increased by Respondent, according to

the progress note for the visit. Respondent also issues prescriptions for Suboxone, Soma, and Adderall to Patient A at this visit.

(ff) On or about March 2, 2021, Patient A returns to NMG for a follow-up visit. Patient A is "tapered off" of Suboxone, according to the progress note for the visit. Patient A's Ambien prescription is doubled by Respondent, according to the note. Respondent also issues prescriptions for Soma and Adderall to Patient A at this visit.

(gg) On or about March 22, 2021, Patient A returns to NMG for a follow-up visit. Patient A is experiencing "withdrawal symptoms from cessation of suboxone" which includes anxiety and insomnia, according to progress note for visit. Respondent increases Soma and Ambien prescriptions at Patient A's request, according to the note.

(hh) On or about August 18, 2021, Patient A returns to NMG for medication refills. Patient A complains of "overactive autonomic nervous system since stopping suboxone," according to progress note for visit. Despite HPI indicating that Suboxone is no longer prescribed to Patient A, Suboxone continues to be listed under current medications in the progress note.

(ii) From in or around January 2021, to in or around August 2021, Respondent and FNP P.F. charted approximately 9 clinical visits with Patient A at NMG. Significantly, Respondent continued issuing concomitant prescriptions for Suboxone, Soma, Ambien, and Adderall to Patient A. The general/psychiatric examination language contained in the progress notes remain mostly identical in 2021.

(jj) From in or around January 2016, to in or around August 2021, the progress notes do not accurately document the exact quantities of Suboxone, Soma, Ambien, and Adderall prescribed to Patient A during this timeframe.

(kk) From in or around January 2016, to in or around August 2021, the progress notes do not document an accurate current medication list of drugs prescribed to Patient A during this timeframe.

(ll) From in or around January 2016, to in or around February 2021, Respondent, with full knowledge of Patient A's OUD, does not clearly document the rationale for multiple changes in dose and/or quantity of Suboxone prescribed to Patient A during this timeframe.

(mm) From in or around January 2016, to in or around February 2021, Respondent, with full knowledge of Patient A's OUD, does not competently manage Patient A's Suboxone treatment and/or orderly taper the dose during this timeframe.

31. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent issued multiple concomitant prescriptions of Suboxone and Soma, which drug combination posed serious risks to Patient A's health;

(b) Respondent issued multiple concomitant prescriptions of Suboxone, Soma, and Ambien, which drug combination posed serious risks to Patient A's health;

(c) Respondent issued multiple concomitant prescriptions of Suboxone, Soma, Ambien, and Adderall, which drug combination posed serious risks to Patient A's health;

(d) Respondent failed to accurately document performance of physical and/or psychiatric examinations of Patient A, which language appears identical/word for word in multiple progress notes over several years;

(e) Respondent failed to accurately document the exact quantities of Suboxone, Soma, Ambien, and Adderall prescribed to Patient A in the progress notes;

(f) Respondent failed to maintain an accurate current medication list of drugs prescribed to Patient A in the progress notes;

(g) Respondent failed to competently manage Patient A's Suboxone treatment and/or orderly taper the dose prescribed to Patient A;

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(h) Respondent diagnosed Patient A with ADHD based on symptoms of inattention, but failed to document any consideration on the combined effects of concomitant prescriptions of three sedatives (i.e., Suboxone, Soma, and Ambien) being taken by Patient A;

(i) Respondent failed to document the rationale for prescribing Adderall to Patient A rather than first attempting a taper of Soma and Ambien;

(j) Respondent failed to adequately and accurately document Patient A's medical record, wherein he documented that Patient A had "tapered off suboxone" and agreed to no longer take the drug, without any further explanation in the progress note dated January 28, 2020; and

(k) Respondent failed to document the rationale for the rapid dose escalation of Adderall prescribed to Patient A on or about June 16, 2020.

32. **Patient B**

(a) From in or around January 2017, to in or around February 2019, Patient B treated with Respondent and FNP P.F. at NMG.[6] During that timeframe, Respondent and FNP P.F. saw Patient B for a number of chronic medical issues including, but not limited to, opioid addiction, chronic pain syndrome, chronic fatigue, low back pain, diabetes, Lyme disease, chronic urethritis, heart problems, sleep apnea, prostate cancer, and depression. During that same timeframe, Respondent and FNP P.F. regularly issued prescriptions to Patient B for controlled substances and other prescription only medication including, but not limited to, Suboxone, Norco, OxyContin, oxycodone HCL, Lorazepam, Diazepam, Ambien, methocarbamol, baclofen, hydroxyzine, selegiline, and naltrexone.

(b) On or about January 5, 2017, Patient B, a then-73-year-old male, presented at NMG for infusion therapy. Under HPI in the progress note, Patient B also complains of fatigue and pudendal pain. Under the current medications list, the

[6] Patient B has been Respondent's patient for 35 years, according to Respondent.

following drugs are listed: hydroxyzine, selegiline, DHEA, naltrexone, Diazepam, Lorazepam, baclofen, methocarbamol.[7] This medication list is reviewed and reconciled with Patient B, according to the progress note for the visit.

(c) On or about February 14, 2017, Patient B returns to NMG for a follow-up visit. Patient B complains of increased "intolerable pain," according to the progress note for the visit. A prescription for Norco is refilled at this visit, but the drug is not listed under current medications in the note.

(d) On or about March 14, 2017, Patient B returns to NMG for a follow-up visit. A pain management consult is ordered, according to the progress note for the visit. A prescription for Norco is refilled at this visit, and the drug is added to the current medications list in the note.

(e) On or about March 17, 2017, Patient B was seen at Integrated Pain Specialists (IPS) by a pain management specialist (Dr. K.S.) for a consultation. Respondent is listed as Patient B's primary care provider, according to the progress note for the visit. Dr. K.S. advises Patient B that he is "not a candidate for chronic oral systemic opioid therapy" and documents alternative methods for pain management in the note. Dr. K.S. further advises Patient B that he does not recommend taking a combination of opioids and benzodiazepines "due to the increased risk of respiratory depression and death." Significantly, Patient B discloses his prior use of hallucinogenic drugs, participation in an alcohol/drug treatment program, and that he had attended "AA" and "NA" meetings.

(f) On or about March 28, 2017, Patient B returns to NMG for a follow-up visit. Patient B advises that Dr. K.S. cannot prescribe him pain medication until he receives medical records and test results, according to the progress note for the visit. A prescription for Norco is refilled at this visit, but the drug is still not listed under current medications in the note.

[7] These same medications remain consistently listed under current medications in every progress note from January 2017 to February 2019.

(g) On or about May 9, 2017, Patient B returns to IPS for medication refills. Patient B is switched from Norco to Percocet, according to the progress note for the visit. The note also indicates that Patient B will proceed with a spinal cord stimulation trial later that week.

(h) On or about July 6, 2017, Patient B has a telephonic encounter with staff at IPS. Patient B states that he wants to "get off the pain medication," and that Respondent has a plan to wean him off of the pain medications, according to documentation of the telephone call. It is also documented that Patient B was given a list of detox facilities to coordinate his care.

(i) In or around 2017, Respondent and FNP P.F. charted approximately 75 clinical visits with Patient B at NMG. Significantly, in 2017, Respondent routinely issued concomitant prescriptions for (1) opioids and benzodiazepines; (2) naltrexone and oxycodone; and (3) hydroxyzine, selegiline, baclofen, and methocarbamol. In 2017, according to CURES, Respondent consistently issued prescriptions for controlled substances to Patient B, but the progress notes do not accurately document if these prescriptions were issued at clinical visits. The progress notes do not document an accurate current medication list of drugs prescribed to Patient B in 2017. The progress notes do not adequately document objective goals of therapy for Patient B and/or the degree to which they were met or not met by treatment in 2017. Respondent did not adequately document in progress notes the rationale for changing the doses of controlled substances that he had prescribed to Patient B in 2017. The progress notes do not document any discussion with Patient B concerning aberrant drug behavior, or document whether any evidence of aberrant drug behavior was observed and/or not observed in 2017. Finally, in light of their knowledge that Patient B was being treated for chronic pain by Dr. K.S., Respondent and/or FNP P.F. did not adequately document in progress notes the rationale for their continued use of controlled drug therapy in treating and managing Patient B's chronic pain issues in 2017.

(j) On or about January 2, 2018, Patient B returns to NMG for a trigger point injection. Patient B states that the neurostimulator was helpful in reducing his pain levels and wants to continue with the therapy, according to the progress note for this visit. The progress note does not accurately document the current medications being prescribed to Patient B by Respondent. Respondent issues a prescription for OxyContin 20mg (#90) to Patient B at this visit. However, the actual quantity of this OxyContin prescription filled by Patient B was #120, according to CURES.

(k) On or about January 19, 2018, Patient B returns to NMG for implantation of a Stivax neurostimulator. The progress note does not document any objective goals of this specific therapy for Patient B.

(l) On or about March 1, 2018, Patient B returns to NMG for ozone treatment. The progress note does not accurately document the current medications being prescribed to Patient B by Respondent. The note does not document any prescription for OxyContin being issued at this visit. However, on or about the same date of this visit, Patient B filled a prescription of OxyContin 30mg (#90), according to CURES.

(m) On or about March 22 and 29, and April 5, 2018, Patient B filled three separate prescriptions issued by Respondent for OxyContin, according to CURES. There is no documentation in Patient B's progress notes showing these prescriptions were issued by Respondent; and nor why the drug's milligram strength was increased to 40mg.

(n) On or about August 5, 2018, Patient B returns to NMG for a follow-up visit. Patient B reports that he is still experiencing "detox symptoms from opioids," according to the progress note for the visit. Patient B also reports that he "does not feel he can manage pain on current psychotropic meds alone." "No suicidal ideation at present," according to Respondent. Respondent then diagnoses Patient B with opioid dependence with withdrawal, and issues a prescription for Suboxone 4mg-

1mg (#10) at this visit. However, Respondent does not first discuss or document discussing with Patient B the risks and benefits of beginning Suboxone treatment.

(o) On or about August 8, 2018, Patient B returns to NMG for a follow-up visit. In the progress note for this visit, Respondent documents an identical psychiatric examination of Patient B that he had just performed only 2 days earlier. Respondent issues a new prescription for Suboxone 8mg-2mg (#30) to Patient B. However, Respondent does not document in the progress note the rationale for increasing the Suboxone prescription at this visit. Respondent again does not discuss or document discussing with Patient B the risks and benefits of beginning Suboxone treatment.

(p) On or about September 12, 2018, Patient B returns to NMG for a trigger point injection. The progress note for this visit indicates "chronic pain stable on suboxone." Patient B wants a trigger point injection for chronic back pain, and he also complains of chronic fatigue. The note documents an identical psychiatric examination of Patient B that was recently performed at prior visits. A review of CURES indicates no inappropriate activity and Patient B "signed a narcotic contract," according to the note. The naltrexone prescription is documented as continued ("every day"), but the note does not document that a prescription was issued for Suboxone. However, Patient B filled a prescription issued by Respondent for Suboxone 8mg-2mg (#30) on or about September 14, 2018, according to CURES.

(q) In or around 2018, Respondent and FNP P.F. charted approximately 75 clinical visits with Patient B at NMG. Significantly, in 2018, Respondent routinely issued concomitant prescriptions for (1) opioids and benzodiazepines; (2) naltrexone and oxycodone; and (3) hydroxyzine, selegiline, baclofen, and methocarbamol. In 2018, according to CURES, Respondent consistently issued prescriptions for controlled substances to Patient B, but the progress notes do not accurately document if these prescriptions were issued at clinical visits. The

progress notes do not document an accurate current medication list of drugs prescribed to Patient B in 2018. The progress notes do not adequately document objective goals of therapy for Patient B and/or the degree to which they were met or not met by treatment in 2018. Respondent did not document in progress notes the rationale for changing the dosage of Suboxone that he had prescribed to Patient B in 2018. The psychiatric examination language contained in many of the progress notes are mostly identical in 2018. Finally, the progress notes do not document any discussion with Patient B concerning aberrant drug behavior, or document whether any evidence of aberrant drug behavior was observed and/or not observed in 2018.

(r) On or about January 3, 2019, Patient B returns to NMG for ozone treatment. Chronic pain and depression are documented in the progress note for this visit. A psychiatric examination documented in the note is identical to prior examinations performed by Respondent. The note does not list Suboxone under current medications, or whether the drug was even prescribed at this visit. However, Patient B filled a prescription issued by Respondent for Suboxone 4mg-1mg (#30) on or about January 4, 2019, according to CURES.

(s) On or about January 31, 2019, Patient B returns to NMG for ozone treatment. Chronic pain, depression, and neuropathy are documented in the progress note for this visit. A psychiatric examination documented in the note is identical to prior examinations performed by Respondent. Again, the note does not list Suboxone under current medications, or whether the drug was even prescribed at this visit. However, Patient B filled a prescription issued by Respondent for Suboxone 4mg-1mg (#60) on or about February 2, 2019, according to CURES.

(t) From in or around January 2017, to in or around February 2019, Respondent does not carefully evaluate and monitor Patient B's polypharmacy.

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33. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent issued multiple concomitant prescriptions of naltrexone and oxycodone, which drug combination posed serious risks to Patient B's health;

(b) Respondent issued multiple concomitant prescriptions of naltrexone and Suboxone, which drug combination posed serious risks to Patient B's health;

(c) Respondent issued multiple concomitant prescriptions of opioids and benzodiazepines, which drug combination posed serious risks to Patient B's health;

(d) Respondent issued multiple concomitant prescriptions of hydroxyzine, selegiline, baclofen, and methocarbamol, which drug combination posed serious risks to Patient B's health;

(e) Respondent failed to adequately evaluate and monitor Patient B's polypharmacy;

(f) Respondent failed to maintain an accurate current medication list of drugs prescribed to Patient B in the progress notes;

(g) Respondent failed to accurately document in the medical record each controlled substance prescribed to Patient B;

(h) Respondent failed to adequately document in progress notes the rationale for changing the doses of controlled substances that he had prescribed to Patient B;

(i) Respondent failed to adequately document in progress notes the rationale for changing the dosage of Suboxone that he had prescribed to Patient B;

(j) Respondent failed to adequately document objective goals of therapy for Patient B and/or the degree to which they were met or not met by treatment;

(k) Respondent failed to adequately monitor Patient B for evidence of aberrant drug behavior; and

(l) Respondent failed to maintain an adequate and accurate medical record, which included frequent use of inaccurate cut-and-paste content carried forward from progress note to progress note.

34. **Patient C**

(a) On or about December 22, 2015, Respondent saw Patient C, a then-4-year-old female, for the first time at NMG's clinic. Patient C's parents requested an immunization waiver from Respondent during the visit at NMG. This was Patient C's first and only documented visit at NMG.

(b) During the visit, Respondent performs a physical examination of Patient C. According to the progress note of the visit, Respondent documents "normal growth and development" and notes an ongoing molluscum infection "for several months." The progress note indicates that Patient C was not taking any current medication, had no surgical history or medical history, and that she was otherwise healthy.

(c) Respondent documents additional information in the progress note, as given to him by Patient C's parents, including, a history of mild eczema and a strong family history of autoimmune disease. Despite the history relayed to him by the parents, Respondent does not order a work-up for possible immune deficiency or issue a referral to a pediatric immunologist. Respondent does not document that Patient C, herself, had suffered from severe, opportunistic, or frequent infections in the past, or had an immune deficiency.

(d) On the same date of the initial clinical visit, Respondent drafts a handwritten letter on NMG letterhead recommending that Patient C "not be vaccinated due to symptoms of impaired immunity and a strong family history of autoimmune disease." The letter is addressed "To whom it may concern" and it is signed by the Respondent.

(e) On or about August 18, 2016, Respondent signs a form entitled "Medical Exemption to Required Immunizations," which is prepared on behalf of Patient C. The form exempts Patient C from all mandatory immunizations for entering school including: Polio; DTaP; MMR; HIB; Hepatitis B; Varicella; and Tdap. Significantly, the form gives "permanent exemption" from these mandatory immunizations to Patient C. By signing the form as a licensed physician, Respondent certified that Patient C had a "physical condition or medical circumstance such that immunization otherwise required for admission to school ... in California is not considered safe." There is no documentation that Respondent saw and/or physically examined Patient C after the December 22, 2015 clinical visit, before signing this form 8 months later.

(f) Patient C's medical records from NMG do not contain copies of medical records from outside medical providers and/or copies of lab tests about the past and then-existing condition of her immunity.

(g) Respondent, without the benefit of additional medical information, relied upon information given to him by Patient C's parents to conclude that she should be exempted from mandatory immunizations.

(h) Respondent, despite having a very limited medical history, hand-wrote and signed a letter recommending Patient C should not be vaccinated; and 8 months later, signed a form certifying that Patient C's immunity condition warranted permanent exemption from all mandatory school aged immunizations.

35. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent failed to provide adequate and supported reasons for the medical exemptions he provided to Patient C;

(b) Respondent failed to adequately act on impaired immunity concerns for Patient C;

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(c) Respondent failed to provide adequate and supported reasons for exempting Patient C from all vaccines; and

(d) Respondent failed to provide adequate and supported reasons for providing permanent exemption to Patient C from all vaccines.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

36. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 44909 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

37. **Patient A**

(a) Paragraphs 29, 30, and 31, above, are hereby incorporated by reference and realleged as if fully set forth herein.

38. **Patient B**

(a) Paragraphs 29, 32 and 33, above, are hereby incorporated by reference and realleged as if fully set forth herein.

39. **Patient C**

(b) Paragraphs 29, 34, and 35, above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient D**

(a) On or about June 23, 2017, Patient D, a then-34-year-old female, had her first documented visit at Respondent's clinic. Respondent saw Patient D and documents in the progress note for the initial visit that she is there "to discuss Trina Therapy." Respondent documents a limited medical history of Patient D and diabetes complications. The progress note indicates that Patient D had diabetes since the age of twelve, that she is insulin dependent, and that she is "currently on pump." The note does not document whether Respondent performed a physical examination, whether Respondent reviewed home blood glucose monitoring data,

or whether Respondent reviewed the specific amounts of insulin then-currently being taken by Patient D.

(b) Significantly, in the progress note from the first visit, Respondent does not document whether Patient D should follow up with a primary care physician (PCP) or an endocrinologist to manage her insulin pump and monitor her for diabetic complications, once Trina therapy was started at NMG. Respondent schedules Patient D to begin Trina therapy without first attempting to review medical records from other medical providers documenting information and/or data about her diabetes complications. Furthermore, neither Respondent nor FNP P.F. ever review any medical records from other providers for Patient D during her Trina therapy, according to the patient's medical record from NMG.

(c) From in or around July 2017, to in or around August 2017, Patient D had 8 documented visits at NMG for Trina therapy. The progress notes for these visits were all signed by FNP P.F. Respondent does not counter-sign or initial any of these notes. Significantly, during this timeframe, there is no documentation that Respondent saw Patient D and/or monitored the Trina therapy that she is receiving at his clinic.

(d) All of the progress notes signed by FNP P.F. list Respondent's name as "PCP" at the top of each note. However, the notes do not include diabetes monitoring and screening information including, but not limited to: no referrals for eye exams; no lab orders to check for microalbuminuria or dyslipidemia; and no foot examinations to check for neuropathy.

41. **Patient E**

(a) On or about June 23, 2017, Patient E, a then-69-year-old male, had his first documented visit at Respondent's clinic. Respondent saw Patient E and documents a very brief progress note for the initial visit, with almost no medical history and/or history of diabetes complications about Patient E in the note. The note indicates that Patient E has insulin dependent diabetes, that he is starting to

get neuropathy, that he is currently on humulin and nvovolin insulins, and that he complains of fatigue. The note does not document whether Respondent performed a physical examination, whether Respondent reviewed home blood glucose monitoring data, or whether Respondent reviewed the specific amounts of insulin then-currently being taken by Patient E.

(b) Significantly, in the progress note from the first visit, Respondent does not document whether Patient E should follow up with a PCP or an endocrinologist to manage his insulin and monitor his diabetic complications, once Trina therapy was started at NMG. Respondent schedules Patient E to begin Trina therapy without first attempting to review medical records from other medical providers documenting information and/or data about his diabetes complications. Furthermore, neither Respondent nor FNP P.F. ever review any medical records from other providers for Patient E during his Trina therapy, according to the patient's medical record from NMG.

(c) From in or around July 2017, to in or around October 2018, Patient E had approximately 58 documented visits at NMG for Trina therapy. The progress notes for these visits were all signed by FNP P.F. Respondent does not counter-sign or initial any of these notes. Significantly, during this timeframe, there is limited documentation that shows Respondent monitored the monthly Trina therapy that Patient E was receiving at his clinic.

(d) All of the progress notes signed by FNP P.F. list Respondent's name as "PCP" at the top of each note. However, the notes do not include diabetes monitoring and screening information including, but not limited to: no referrals for eye exams; no foot examinations to check for neuropathy; only one (1) lipid panel was checked and documented; and no substantive documentation related to managing Patient E's elevated blood pressure readings and attendant cardiovascular risk factors.

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42. Respondent committed repeated negligent acts in his care and treatment of Patients D and E including, but not limited to, the following:

(a) Respondent failed to properly monitor the diabetes care and treatment that Patient D received at his clinic;

(b) Respondent failed to document an adequate medical history of Patient D;

(c) Respondent failed to properly monitor the diabetes care and treatment that Patient E received at his clinic; and

(d) Respondent failed to document an adequate medical history of Patient E.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

43. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 44909 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in his care and treatment of Patient A, as more particularly alleged hereinafter:

44. **Patient A**

(a) Paragraphs 29, 30, and 31, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(b) During his subject interview on or about June 17, 2021, Respondent is asked a question about why a prescription for Suboxone is missing from the current medication list in the progress note, to which he replies, "I don't really know. ... I don't manage that part of the record."

(c) From in or around January 2016, to in or around February 2021, Respondent does not adequately document in the progress notes the rationale for multiple dose changes of Suboxone for treating Patient A's OUD during this timeframe.

(d) From in or around January 2016 to in or around February 2021, Respondent, with full knowledge of Patient A's OUD and polypharmacy, does not document any consideration of a diagnosis of polysubstance use disorder during this timeframe.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

45. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 44909 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 29 through 44, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

46. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 44909 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 29 through 45, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 44909, issued to Respondent James Anthony Novak, M.D.;

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

3. Ordering Respondent James Anthony Novak, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAY 25 2022

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

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