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

In the Matter of the Accusation Against:	)	
STEPHANIE ANN HIGGINS, M.D.	)	Case No. 03-2012-225248
Physician's and Surgeon's Certificate No. A 70849	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 9, 2016.

IT IS SO ORDERED: November 10, 2016.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
MACHAELA M. MINGARDI
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **STEPHANIE HIGGINS M.D.** 3794 Highland Road, Lafayette, CA 94549 Physician's and Surgeon's Certificate No. A70849 Respondent.	Case No. 03-2012-225248 OAH Case No. 2016020805 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Machaela M. Mingardi, Deputy Attorney General.

2. Respondent Stephanie Higgins M.D. (Respondent) is represented in this proceeding by attorney Frank Z. Leidman, whose address is: Frank Z. Leidman, Leidman Law, 345 Franklin Street, Suite 105, San Francisco, CA 94102-4427.

3. On or about February 11, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate No. A70849 to Stephanie Higgins M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 03-2012-225248, and will expire on June 30, 2017, unless renewed. On June 18, 2014, the Santa Clara Superior Court issued an order prohibiting Respondent from prescribing controlled substances, including recommending medical marijuana, during the pendency of an action there.

JURISDICTION

4. Accusation No. 03-2012-225248 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 23, 2014. Respondent filed her Notice of Defense contesting the Accusation. A First Amended Accusation was filed and served on March 11, 2015.

5. A copy of First Amended Accusation No. 03-2012-225248 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation No. 03-2012-225248. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 03-2012-225248, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up her right to contest those charges.

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

RESERVATION

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

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A70849 issued to Respondent Stephanie Higgins M.D. is revoked. However, revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions:

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 90 days beginning the sixteenth (16th) day after the effective date of this decision.

2. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or

cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

Notwithstanding the provisions of Business and Professions Code section 2307, This Partial Restriction shall be in force and effect for no less than four years of Respondent's five-year probationary term.

3. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances she is authorized to order, prescribe, dispense, administer, or possess, and if during the course of probation, Respondent is authorized to recommend or approve a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, the record shall maintain all of the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection

and copying on the premises by the Board or its designee, as well as Respondent's practice monitor, at all times during business hours and shall be retained for the entire term of probation.

4. 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.

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

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, 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.

6. 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 equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, 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.

7. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after

Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

8. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, 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, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

Respondent shall not practice medicine until Respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that Respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

9. MONITORING - PRACTICE. At least 30 days before resuming practice, 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 Accusations, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusations, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decisions and Accusations, 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.

Throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.

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

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

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

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

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

12. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is

prohibited from supervising physician assistants.

13. 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. A criminal conviction on the criminal charges currently pending in Santa Clara County Superior Court, Case No. CL1484829, which stems from the same conduct at issue in this matter, will not be considered a violation of Respondent's probation herein.

14. 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.

15. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

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

Place of Practice

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

License Renewal

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

license.

Travel or Residence Outside California

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

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

16. 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.

17. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice 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; and General Probation Requirements.

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

19. 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.

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

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

year.

ACCEPTANCE

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

DATED: 07/13/2016

STEPHANIE HIGGINS M.D.
Respondent

I have read and fully discussed with Respondent Stephanie Higgins 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: July 13, 2016

FRANK Z. LEIDMAN
Attorney for Respondent

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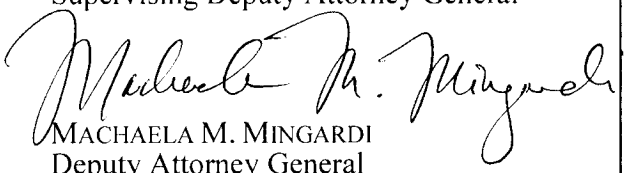
ENDORSEMENT

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

Dated: July 13, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General



MACHAELA M. MINGARDI
Deputy Attorney General
Attorneys for Complainant

SF2014408323

Exhibit A

First Amended Accusation No. 03-2012-225248

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO MARCH 11, 2015
BY: JYE LCHAK ANALYST

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

In the Matter of the First Amended Accusation Against: **STEPHANIE HIGGINS M.D.** **4155 Amaranta Avenue** **Palo Alto, CA 94306** **Physician's and Surgeon's Certificate No. A70849** Respondent.	Case No. 03-2012-225248 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about February 11, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate Number A70849 to Stephanie Higgins M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2015, unless renewed. Respondent's Certificate is restricted pursuant to a June 18, 2014, Order issued by the Santa Clara County

Superior Court, which prohibits Respondent from obtaining, ordering or using any controlled substance prescription form, and prescribing or recommending any controlled substances.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board),[1] Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in relevant part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code, states, in relevant 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:

[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" or "Division" shall also be deemed to refer to the Board (Bus. & Prof. Code section 2002).

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

7. Section 725 of the code provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of community of licensee is unprofessional conduct.

8. Section 2242(a) provides that prescribing, dispensing or furnishing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

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

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Failure to maintain adequate medical records related to the care of Patient JB[2];)

[2] Patient initials are used to protect the patient's privacy. Respondent may learn the patient information during the discovery process.

10. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient JB. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent's medical records for Patient JB lack adequate documentation to support her care and treatment of the patient. The circumstances are as follows:

11. Respondent graduated from medical school in 1992 from the University of Texas, Houston. She began her internal medicine residency at Kaiser Permanente Santa Clara in 1997 but took a leave of absence during her pregnancy. She completed her residency in 2001. Respondent was board certified in internal medicine between 2001 and 2011. Respondent previously worked at two separate private practice offices providing chronic pain management care to the patients of a neurosurgeon and then an anesthesiologist. She then worked as a hospitalist with Mills Peninsula Hospital. In 2010, she began working with clinics[3] providing medical marijuana recommendations until she opened her own clinic in April 2012.

12. On or about January 26, 2012, Patient JB went to 420 Evaluations for a medical marijuana recommendation renewal. During the visit he completed a two-page "Patient Intake Form" indicating he was nineteen years old, that he was seeking the recommendation for "anxiety," that he saw his doctor the prior week for the complaint, and that he had a lymph node removed in his neck. He also indicated that he has tried to treat his "medical issues" with medication, "herbs," physical therapy, and counseling.[4] Patient JB also listed that he was currently taking Klonopin and Remeron.[5] The patient admitted to smoking daily and drinking alcohol every weekend.[6] Respondent did not question Patient JB about any addiction issues, despite his admission to drinking alcohol while underage and smoking marijuana regularly. The patient did not bring any medical records with him, nor did he indicate that he would provide

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[3] Respondent worked for a several medical marijuana clinics, including 420 Evaluations.

[4] The patient did not provide any detail as to which treatment was for which medical condition, including what medications were used to treat the various medical conditions he complained of.

[5] Klonopin is a benzodiazepine used to treat anxiety. Remeron is a tetracyclic antidepressant.

[6] The form does not differentiate between smoking cigarettes versus marijuana; however, there is a separate question about the different methods used to smoke/ingest marijuana.

them in the future. Patient JB also completed a five-page "Disclosure and Informed Consent" form and "Medical Marijuana Patient Agreement" requiring his initials on each paragraph of the various disclosures and agreements.

13. Respondent completed a one-page document that only listed the patient's name, and under Medications she wrote "Anxiety." The note is in the standard SOAP format with vital signs (but no vital signs were noted) and the first three portions of the SOAP note had a line through it. Under the plan portion of the note, Respondent checked the box for "Recommended medical use of marijuana for one year" with a hand written note "RTC in 3 months and PRN for rev." Respondent signed the note and it was date-stamped January 26, 2012 three times.

14. Respondent issued a "Physician Statement and Recommendation" letter to Patient JB that was valid between January 26, 2012 and January 25, 2013.

15. Patient JB indicated that when he met with Respondent, he spoke with her for one to two minutes and then she gave him the recommendation letter. He stated that she did not conduct any physical examination, did not ask him any questions, or take any patient history information from him.

16. On June 26, 2013, during Respondent's interview with Medical Board investigators at the San Jose District Office, she indicated that her evaluations lasted approximately three to five minutes. She also indicated that she would never recommend marijuana for a patient that was under psychiatric care unless she had signed authorization from the psychiatrist.

17. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient JB, including, but not limited to the following:

a. Respondent's medical records for Patient JB lack any meaningful medical information documenting the patient encounter, including the history, current medications, physical examination, tests, the assessment, and treatment plan. The record also failed to detail the symptoms related to the diagnosis, any other treating providers, and an assessment of JB's

psychological status, social functioning, and addiction history. This represents an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient JB's underlying medical condition and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's marijuana recommendation to Patient JB without a medical indication or purpose represents an extreme departure in the standard of care.

d. Respondent's failure to communicate with Patient JB's other medical providers to confirm the diagnosis and treatment plan represents an extreme departure in the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Failure to maintain adequate medical records related to the care of Patient JJ)

18. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and/or 2234(d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient JJ. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent's medical records for Patient JJ lack adequate documentation to support her care and treatment of the patient. The circumstances are as follows:

19. On or about February 4, 2012, Patient JJ went to 420 Evaluations to obtain a medical marijuana recommendation renewal. Patient JJ completed a two-page "Patient Intake Form" that he was nineteen years old with complaints of knee pain. He also indicated he had seen another provider for this issue approximately one month before. The only medication Patient JJ indicated he was taking was marijuana. The patient also circled "cough" under the frequent symptoms section of the form. Patient JJ also completed a three-page "Disclosure and Informed Consent" form but he did not complete the two-page "Medical Marijuana Patient Agreement."

20. Respondent completed a one-page document in the standard SOAP format with vital signs but she did not document any vital signs for Patient JJ. Under the medication and upper half of the SOAP note, Respondent wrote in large somewhat illegible cursive writing "takes away

knee pain [illegible] – tear in ACL-sports injury [illegible]." Under the plan portion of the note, Respondent checked the box for "Recommended medical use of marijuana for one year" with a hand written note "RTC in 3 months and PRN for rev." Respondent signed the note and it was date stamped February 4, 2012 three times.

21. Respondent issued a "Physician Statement and Recommendation" letter to Patient JJ that was valid between February 4, 2012 and February 3, 2013.

22. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient JJ, including, but not limited to the following:

a. Respondent's medical records for Patient JJ lack any meaningful medical information documenting the patient encounter, including the history, current medications, physical examination, tests, the assessment, and treatment plan. The record also failed to detail the symptoms related to the diagnosis, any other treating providers, and an assessment of JJ's psychological status, social functioning, and addiction history. This represents an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient JJ's underlying medical condition and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's marijuana recommendation to Patient JJ without a medical indication or purpose represents an extreme departure in the standard of care.

d. Respondent's failure to communicate with Patient JJ's other medical providers to confirm the diagnosis and treatment plan represents an extreme departure in the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Failure to maintain adequate medical records related to the care of Patient CS)

23. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and/or 2234(d), and/or 2266 of the code in that Respondent committed

unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient CS. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent's medical records for Patient CS lack adequate documentation to support her care and treatment of the patient. The circumstances are as follows:

24. On or about December 18, 2012, Respondent issued a "Physician Statement and Recommendation" letter to Patient CS, an 18-year-old male who was still in high school at the time. The recommendation was valid from December 18, 2012 through December 17, 2013.

25. CS had been using marijuana daily for approximately two years, including the portion of time when he had a valid recommendation issued by Respondent. In April 2013, CS reported to mental health professionals that he had begun hallucinating, hearing voices, and could not sleep while previously using marijuana. CS began treatment with the Kaiser Permanente Psychiatry Department to treat CS's mental health issues, including his dependence on marijuana.

26. During Respondent's interview with Board investigators, she admitted that she had no patient records for CS nor did she recall the patient.

27. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient CS, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounter, including the history, current medications, physical examination, tests, the assessment, and treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient CS's underlying medical condition and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's marijuana recommendation to Patient CS without a medical indication or purpose represents an extreme departure in the standard of care.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Excessive/Inappropriate Prescribing; Failure to maintain adequate medical records related to the care of Patient AM)

28. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient AM. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent has no medical records for Patient AM to support her treatment of the patient. The circumstances are as follows:

29. On April 3, 2012 at 1:47 a.m., the Sunnyvale Police Department pulled over Patient AM in Sunnyvale, California for driving a car with false registration tabs. The car was registered to Respondent. The officer found 23 empty prescription bottles in the back seat of the car, prescribed to several different people. All of the 23 bottles were either prescribed by or to Respondent. They include numerous prescriptions for Patient AM, including prescriptions for Hydrocodone/APAP[7] and Carisoprodol[8].

30. During her interview with the Medical Board, Respondent stated that AM was one of her former household employees who used to help care for her autistic son. She stated he worked for her for five years and that he occasionally lived with her. She stated that on the night of his arrest, AM was driving her vehicle and that he was going to fill a prescription for Prozac that she wrote from her house. She stated that he was very depressed. She stated that she has written prescriptions for Norco[9] for AM. She also gave him a recommendation for a medical marijuana card. She said that often she treated him in her home, but that she saw him seven or

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[7] AM was prescribed Hydrocodone/APAP 10/325 (hydrocodone with acetaminophen), which is a Schedule III controlled substance and narcotic as defined by section 11056(e) of the Health and Safety Code. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence.

[8] Carisoprodol is a muscle relaxant and sedative. Carisoprodol is a dangerous drug as defined by Business and Professions Code section 4022.

[9] Norco is a trade name for Hydrocodone/APAP 10/325 (hydrocodone with acetaminophen), described above.

eight times in her clinic. She stated that she treated AM eight or nine times in her home and that there is documentation.

31. Walgreens and Safeway Pharmacy records show that Respondent prescribed Patient AM 200 tablets of Norco from August to September of 2011 and 470 tablets of Norco from January to March of 2012. Pharmacy records also show that Respondent prescribed 210 tablets of Soma, a brand name for Carisoprodol, to Patient AM in 2012.

32. Despite numerous requests from the Medical Board, Respondent never provided medical records for Patient AM.

33. On February 24, 2014, Medical Board investigators and members of the Palo Alto Police Department executed a search warrant at Respondent's home address. No medical records were found on the premises. On that date, Respondent certified that she had no medical records for Patient AM.

34. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient AM, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounters, including the history, current medications, physical examinations, tests, assessments, and any treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient AM's underlying medical condition, if any, and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's prescribing of controlled substances and dangerous drugs to Patient AM without a medical indication or purpose represents an extreme departure in the standard of care.

35. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that she inappropriately and excessively prescribed

narcotic and sedative medications for Patient AM, in the absence of an appropriate prior medical examination and a medical indication.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Excessive/Inappropriate Prescribing; Failure to maintain adequate medical records related to the care of Patient MB)

36. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient MB. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent has no medical records for Patient MB to support her treatment of the patient. The circumstances are as follows:

37. As described previously, in the early morning hours of April 3, 2012, a Sunnyvale Police Department officer found 23 prescription bottles in the back seat of Respondent's car. Several of these bottles were prescriptions issued by Respondent to Patient MB.

38. During her interview with the Medical Board, Respondent stated that Patient MB is her "significant other" who lives with her and that she has treated him at their home and at her office. She stated that she has prescribed Prozac to MB and, among other things, "just very occasional Norco" because "it makes him too sick to his stomach."

39. Patient prescription information from one Walgreens Pharmacy shows that from 8/1/2011 to 8/15/2012, Respondent's prescriptions to Patient MB that were filled at this Walgreens location include, but are not limited to, the following:

1. Hydrocodone/Acetaminophen, 10-325, 90 pills, 9/3/11.
2. Hydrocodone/Acetaminophen, 10-325, 90 pills, 9/11/11.
3. Hydrocodone/Acetaminophen, 10-325, 90 pills, 9/21/11.
4. Hydrocodone/Acetaminophen, 10-325, 90 pills, 10/12/11.
5. Hydrocodone/Acetaminophen, 10-325, 90 pills, 10/19/11.
6. Hydrocodone/Acetaminophen, 10-325, 100 pills, 11/24/11.

7. Hydrocodone/Acetaminophen, 10-325, 100 pills, 12/25/11.

8. Hydrocodone/Acetaminophen, 10-325, 100 pills, 1/13/12.

9. Hydrocodone/Acetaminophen, 10-325, 100 pills, 2/8/12.

10. Hydrocodone/Acetaminophen, 10-325, 100 pills, 3/5/12.

11. Hydrocodone/Acetaminophen, 10-325, 100 pills, 3/19/12.

12. Hydrocodone/Acetaminophen, 10-325, 100 pills, 3/29/12.

13. Hydrocodone/Acetaminophen, 10-325, 100 pills, 4/9/12.

14. Hydrocodone/Acetaminophen, 10-325, 100 pills, 4/19/12.

15. Hydrocodone/Acetaminophen, 10-325, 100 pills, 5/7/12.

16. Hydrocodone/Acetaminophen, 10-325, 100 pills, 6/14/12.

17. Hydrocodone/Acetaminophen, 10-325, 100 pills, 6/23/12.

18. Hydrocodone/Acetaminophen, 10-325, 100 pills, 7/17/12.

19. Hydrocodone/Acetaminophen, 10-325, 100 pills, 8/1/12.

20. Carisoprodol, 350 mg tabs, 90 pills, 9/21/11.

21. Carisoprodol, 350 mg tabs, 90 pills, 4/9/12.

22. Carisoprodol, 350 mg tabs, 120 pills, 6/23/12.

Thus, this one pharmacy alone showed that Respondent prescribed Patient MB at least 1940 tablets of Hydrocodone/APAP in a one-year period.

40. Despite numerous requests from the Medical Board, Respondent never provided medical records for Patient MB.

41. On February 24, 2014, Medical Board investigators and members of the Palo Alto Police Department executed a search warrant at Respondent's home address. No medical records were found on the premises. On that date, Respondent certified that she had no medical records for Patient MB.

42. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient MB, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounters, including the history, current medications, physical examinations, tests, assessments, and any treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient MB's underlying medical condition, if any, and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's prescribing of controlled substances and dangerous drugs to Patient MB without a medical indication or purpose represents an extreme departure in the standard of care.

43. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that she inappropriately and excessively prescribed narcotic and sedative medications for Patient MB, in the absence of an appropriate prior medical examination and a medical indication.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Excessive/Inappropriate Prescribing; Failure to maintain adequate medical records related to the care of Patient RS)

44. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient RS. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent has no medical records for Patient RS to support her treatment of the patient. The circumstances are as follows:

45. As described previously, in the early morning hours of April 3, 2012, a Sunnyvale Police Department officer found 23 prescription bottles in the back seat of Respondent's car. Several of these bottles were prescriptions issued by Respondent to Patient RS.

46. During her interview with the Medical Board, Respondent stated that RS was her live-in housekeeper and nanny since 2003. Respondent stated that empty prescription bottles in

RS' name were in the backseat of her car because RS was taking the car to the pharmacy. However, later in the interview Respondent stated that RS doesn't drive and doesn't have a driver's license. Respondent stated that she has prescribed Augmentin, albuterol and Vicodin to RS and that she prescribed these to her from her home.

47. Walgreens Pharmacy records show that from August 2011 to June 2012, Respondent prescribed Patient RS 980 tablets of Norco and 450 tablets of Soma.

48. Despite numerous requests from the Medical Board, Respondent never provided medical records for Patient RS.

49. On February 24, 2014, Medical Board investigators and members of the Palo Alto Police Department executed a search warrant at Respondent's home address. No medical records were found on the premises. On that date, Respondent certified that she had no medical records for Patient RS.

50. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient RS, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounters, including the history, current medications, physical examinations, tests, assessments, and any treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient RS' underlying medical condition, if any, and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's prescribing of controlled substances and dangerous drugs to Patient RS without a medical indication or purpose represents an extreme departure in the standard of care.

51. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that she inappropriately and excessively prescribed narcotic and sedative medications for Patient RS, in the absence of an appropriate prior medical examination and a medical indication.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Excessive/Inappropriate Prescribing; Failure to maintain adequate medical records related to the care of Patient KC)

52. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient KC. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent has no medical records for Patient KC to support her treatment of the patient. The circumstances are as follows:

53. As described previously, in the early morning hours of April 3, 2012, a Sunnyvale Police Department officer found 23 prescription bottles in the back seat of Respondent's car. At least one of these bottles was a prescription issued by Respondent to Patient KC.

54. During her interview with the Medical Board, Respondent stated that Patient KC was the aforementioned Patient AM's girlfriend for a long time and that Patient KC watched her children a lot. Respondent stated that she treated Patient KC at Respondent's home and at her office and that she prescribed her Norco, Soma, antidepressants, and Abilify. Respondent stated that she treated Patient KC 12 or 13 times in her office.

55. Safeway and Walgreens Pharmacy records show that from August 2011 to June 2012, Respondent prescribed Patient KC 740 tablets of Norco and 960 tablets of Soma.

56. Despite numerous requests from the Medical Board, Respondent never provided medical records for Patient KC.

57. On February 24, 2014, Medical Board investigators and members of the Palo Alto Police Department executed a search warrant at Respondent's home address. No medical records were found on the premises. On that date, Respondent certified that she had no medical records for Patient KC.

58. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence,

and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient KC, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounters, including the history, current medications, physical examinations, tests, assessments, and any treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient KC's underlying medical condition, if any, and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's prescribing of controlled substances and dangerous drugs to Patient KC without a medical indication or purpose represents an extreme departure in the standard of care.

59. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that she inappropriately and excessively prescribed narcotic and sedative medications for Patient KC, in the absence of an appropriate prior medical examination and a medical indication.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Negligence and/or Incompetence; Excessive/Inappropriate Prescribing; Failure to maintain adequate medical records related to the care of Patient JH)

60. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b), and/or/2234(c), and/or 2234 (d), and/or 2266 of the code in that Respondent committed unprofessional conduct amounting to gross negligence, and/or negligence, and/or incompetence in the care and treatment of Patient JH. Respondent is also subject to disciplinary action under section 2266 of the code in that Respondent has no medical records for Patient JH to support her treatment of the patient. The circumstances are as follows:

61. As described previously, in the early morning hours of April 3, 2012, a Sunnyvale Police Department officer found 23 prescription bottles in the back seat of Respondent's car. Several of these bottles were prescriptions issued by Respondent to Patient JH.

62. During her interview with the Medical Board, Respondent stated that Patient JH is her mother who lives in Texas. Respondent stated that she has called in prescriptions for Patient JH in Texas, although Respondent is not licensed in that state. Respondent stated that she has also treated JH as a patient in California when JH comes to visit.

63. Safeway and Walgreens Pharmacy records show that from October 2011 to March 2012, Respondent prescribed Patient JH 930 tablets of Norco and 300 tablets of Soma.

64. Despite numerous requests from the Medical Board, Respondent never provided medical records for Patient JH.

65. On February 24, 2014, Medical Board investigators and members of the Palo Alto Police Department executed a search warrant at Respondent's home address. No medical records were found on the premises. On that date, Respondent certified that she had no medical records for Patient JH.

66. Respondent's conduct, as described above, constitutes unprofessional conduct and represents an extreme departure in the standard of care, and/or negligence, and/or incompetence, and/or inadequate medical record keeping, in that Respondent committed errors and omissions in the care and treatment of Patient JH, including, but not limited to the following:

a. Respondent's lack of medical records documenting the patient encounters, including the history, current medications, physical examinations, tests, assessments, and any treatment plan, represent an extreme departure in the standard of care.

b. Respondent's failure to diagnose and treat Patient JH's underlying medical condition, if any, and to document that treatment, including whether there are compelling reasons to deviate from the usual course of practice, represents an extreme departure in the standard of care.

c. Respondent's prescribing of controlled substances and dangerous drugs to Patient JH without a medical indication or purpose represents an extreme departure in the standard of care.

67. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2242 and/or 725 of the Code in that she inappropriately and excessively prescribed narcotic and sedative medications for Patient JH, in the absence of an appropriate prior medical examination and a medical indication.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's certificate Number A70849, issued to Stephanie Higgins M.D.

2. Revoking, suspending or denying approval of Stephanie Higgins M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Stephanie Higgins M.D. to pay the Medical Board of California the costs of probation monitoring, if placed on probation;

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

DATED: March 11, 2015

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