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

In the Matter of the Third Amended Accusation Against: John Edward Humiston, M.D. Physician's and Surgeon's Certificate No. A 83402 Respondent.	Case No. 800-2018-048053

DECISION

The attached Proposed Decision 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 March 8, 2023.

IT IS SO ORDERED February 6, 2023.

MEDICAL BOARD OF CALIFORNIA

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

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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Third Amended Accusation Against:

JOHN EDWARD HUMISTON, M.D., Respondent

Agency Case No. 800-2018-048053

OAH No. 2021030917

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference and telephone on September 13 to 16, 2022, and on December 19, 2022.

Christine A Rhee, Deputy Attorney General, represented complainant, William Prasifka, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

John Edward Humiston, M.D., respondent, represented himself.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on December 19, 2022.

PROTECTIVE SEALING ORDER

The names of patients in this matter are subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual name of the patients but shall instead refer to the patients by their corresponding letters as set forth in the Confidential Names List marked and received into evidence under seal as Exhibit 32. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 4, 2003, the board issued Physician's and Surgeon's Certificate Number A83402 to respondent. The Certificate was set to expire on August 31, 2022, unless renewed.[1]

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[1] The certification of licensure issued by the board and received into evidence is dated August 17, 2022, and no updated certification was provided to show whether respondent has renewed his Physician's and Surgeon's Certificate.

2. On December 16, 2020, the board filed accusation number 800-2018-048053 seeking revocation or suspension of respondent's certificate. On July 14, 2021, the board filed the first amended accusation number 800-2018-048053 seeking revocation or suspension of respondent's certificate. On January 19, 2022, the board filed the second amended accusation number 800-2018-048053 seeking revocation or suspension of respondent's certificate. On March 10, 2022, the board filed the third amended accusation number 800-2018-048053 seeking revocation or suspension of respondent's certificate, which is at issue in this matter. The third amended accusation seeks revocation or suspension of respondent's certificate based upon three causes for discipline related to his care and treatment of six patients, namely (1) gross negligence for his care and treatment of Patients A, C, D, E, and F; (2) repeated negligent acts for his care and treatment of Patients A, B, C, D, E, and F; and (3) failure to maintain adequate and accurate records with regard to Patient B.

3. Respondent timely filed a notice of defense, and this hearing followed.

Disciplinary History

4. On March 7, 2018, the board filed an accusation number 800-2015-014545 against respondent seeking revocation or suspension of his certificate based upon three causes for discipline, namely: (1) gross negligence for his care and treatment of one patient, (2) repeated negligent acts for his care and treatment of two patients, and (3) violations of the Medical Practice Act related to his care and treatment of the same two patients. Pursuant to a Stipulated Settlement, the board issued a Decision and Order on January 24, 2019, effective February 22, 2019, wherein respondent's certificate was publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4), and respondent was required to

complete 20 hours of continuing medical education. The Stipulated Settlement and Decision and Order included the following paragraph agreed to by respondent:

> 9. Respondent further agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 8002015014545 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 or elsewhere.

Respondent's Motion to Exclude Evidence as Incomplete

5. At the beginning of the hearing respondent made a motion to exclude all evidence related to patient charts for all six patients at issue based upon his assertion that the patient charts were incomplete. Complainant opposed the motion on the basis that complainant obtained all patient records during its investigation and provided all of those records to respondent. Complainant asserts that if respondent believed the records were incomplete, respondent had the opportunity to subpoena any records that were not produced, if any such records exist. Respondent was unable to identify any particular record he asserted exists but was not produced, and accordingly respondent's motion was denied.

Complainant's Evidence

6. Complainant provided testimony from three witnesses, two of whom are expert witnesses, and one is the board's investigator. Dr. Cynthia Watson provided expert testimony regarding respondent's care and treatment of Patients A and B. Dr. Dean Blumberg provided expert testimony regarding respondent's issuance of vaccine

exemptions for Patients C, D, E, and F. The board's investigator provided testimony regarding the board's investigation and efforts to obtain complete documentation of respondent's care and treatment of the patients at issue.

THE BOARD'S INVESTIGATION

7. Rashya Henderson is currently employed by the board as a Supervising Special Investigator, a position she has held since 2009. Ms. Henderson started the complaint investigation office and created its policies and procedures when the board created that office. In this position she supervises seven investigators, each of whom oversee approximately 30 to 40 investigations at any given time. In addition to supervising these individuals, Ms. Henderson also conducts investigations herself, and has investigated approximately 70 to 80 vaccine exemption cases for the board, as well as other cases involving medical malpractice, criminal convictions, and other violations of the Medical Practice Act. Ms. Henderson's duties include review and approval of subpoenas, assisting staff in interpreting laws and regulations, and training all staff in various investigative techniques. Ms. Henderson has extensive training on investigations, including over 1,000 hours from various agencies, including the Attorney General's office. Ms. Henderson was involved in the board's investigation of the vaccine exemptions respondent issued for Patients C, D, E, and F. Ms. Henderson was not involved in the investigation of respondent regarding his care and treatment of Patients A and B.

8. Ms. Henderson has been trained on the policies and procedures in how to obtain patient medical records related to board investigations and testified regarding that process. The first step involves reviewing the information available and obtaining patient names and contact information. The board will then send a request to the patient for a signed release of medical information. If the board receives a

signed release from the patient, then the board will forward that document to the medical facility requesting medical records for a specific time frame at issue. If the board does not obtain a signed release from the patient, then the board has a medical consultant review the case for a determination if there is enough information to move forward with an investigation. If there is sufficient information to move forward with an investigation, then the board will issue a subpoena for the medical records. Prior to issuing a subpoena, the board will notify the patient at issue about the subpoena, the time frame of the medical records request, and when the records are due, as well as a notification of the patient's rights, how the board intends to use the medical records, and a copy of the subpoena. Ms. Henderson testified that after sending the patient notice of a subpoena, typically the board does not hear from the patient, but the patient has a right to object to the production of medical records to the board. If the patient objects to the production, Ms. Henderson consults with the Attorney General's office regarding the objections. If no objections are received, then the board waits for the medical records to be produced by the medical facility and only after the time for patient objection has elapsed does the board review those records. Ms. Henderson, or the assigned investigator, then reviews the records to make sure all requested records have been produced.

Ms. Henderson explained that there are consequences to a medical facility if all requested records have not been produced pursuant to either a valid subpoena or a signed authorization from the patient. In addition to requesting the medical records from the medical facility, the board also requests an executed declaration or certification of records by the custodian of records for that facility, which includes the patient's name, facility name and address, total page count of records provided, as well as time frame of records provided. Ms. Henderson explained that the record request is not fulfilled without the signed declaration or certification from the

custodian of records. Ms. Henderson has completed this process hundreds of times in her career. Many times, she finds that the custodian of records fails to complete the declaration document or does so incorrectly. In those cases, Ms. Henderson, or the assigned investigator, will follow up with the medical facilities.

9. In March 2019 Ms. Henderson was assigned to investigate respondent based on a complaint the board received related to a news article regarding the results of a public records request for information from the San Diego Unified School District (SDUSD) related to vaccination exemptions provided to school-aged children in the district. The complaint included a spreadsheet with a list of physicians who had provided the most vaccination exemptions for school-aged children in the district. Respondent was one of the top five physicians who had written the most vaccination exemptions. As a result of this information Ms. Henderson issued a subpoena to the SDUSD to obtain unredacted copies of the vaccination exemptions to move forward with her investigation. The SDUSD attempted to comply with the subpoena, but a parent group objected to the subpoena and filed a lawsuit regarding the subpoena. Accordingly, it took two years for the board to obtain the documents through the subpoena after the lawsuit was resolved. Ultimately, on November 19, 2021, Ms. Henderson received all the documents requested by the subpoena from the SDUSD, which provided the full names of the student/patients who received vaccine exemptions.

Thereafter, Ms. Henderson mailed a request for a signed authorization for release of medical records to the board for each of the student/patients identified who received an exemption from respondent. Ms. Henderson received one signed authorization back from the parent of Patient F. Ms. Henderson took the signed release and provided it to the Center for Health and Wellbeing (CHW), the medical

facility where respondent worked at that time, and received a response and certification stating that no records were found for Patient F. Ms. Henderson interviewed Patient F's mother, who informed her that Patient F saw respondent on one occasion only to obtain the vaccine exemption and had no further care or appointments with respondent.

With regard to Patients C, D, and E, Ms. Henderson did not receive signed authorizations for release of the records from those patients. For these three patients, Ms. Henderson issued subpoenas to the CHW for those records and CHW responded to each of those subpoenas.

With regard to Patient C, Ms. Henderson received 52 pages of documents from CHW regarding Patient C on January 28, 2022, but the certification of records stated that there was a total of 26 pages of documents. Ms. Henderson contacted CHW regarding this discrepancy in August 2022. In response to Ms. Henderson's request for clarification, CHW produced a second set of documents regarding Patient C consisting of 62 pages with a corrected certification of records that was correct. Ms. Henderson received the second set of documents on September 1, 2022. She stated that the second set of documents produced included an additional 10 pages not originally produced.

With regard to Patient D, Ms. Henderson received 25 pages of documents from CHW regarding Patient D on January 28, 2022, with a certification of records that was incorrect and stated that they provided 13 pages of documents. Ms. Henderson contacted CHW regarding this discrepancy, and in response to Ms. Henderson's request for clarification, CHW produced a second set of documents regarding Patient D consisting of 24 pages with a corrected certification of records that was correct. Ms. Henderson noted that the original production of documents for Patient D included

one additional page not included in the second set of documents produced. That single page only had the patient's name on it and nothing else. Otherwise, both productions of documents were identical.

With regard to Patient E, Ms. Henderson received 114 pages of documents from CHW regarding Patient E on January 28, 2022, with a certification of records that was incorrect and stated that they provided 63 pages of documents. Ms. Henderson contacted CHW regarding this discrepancy, and in response to Ms. Henderson's request for clarification, CHW produced a second set of documents regarding Patient E consisting of 116 pages with a corrected certification of records that was correct. Ms. Henderson testified that the additional two pages consisted of one blank page and one page with a copy of an ID card placed over the page that was not present in the previous production. Otherwise, there were no differences between the two productions of documents.

10. Ms. Henderson also attempted to interview respondent as part of her investigation. However, the interview with respondent never happened. Ms. Henderson gave respondent the opportunity to provide a written summary of care and treatment with a couple of questions to which he was asked specifically to respond. Ms. Henderson also provided respondent with a copy of the patients' records for his review so that he could respond to the questions. Respondent provided his written response on March 4, 2022.

11. Ms. Henderson stated that to the best of her knowledge, the records she received from CHW for each of Patients C, D, E, and F were full and complete as certified by the custodian of records from CHW. She is not aware of any document that exists but was not produced, and she would not be privy to the records created or

kept by CHW other than those that were provided with an executed certification regarding their completeness.

TREATMENT AND CARE OF PATIENTS A AND B

12. Patient A was treated by respondent from November 2017 to February 2018 utilizing the NeuroRecover program as a method to get Patient A off of numerous medications related to depression, anxiety, and Post Traumatic Stress Disorder (PTSD). Patient B, who is Patient A's wife, was treated by respondent from February 2018 to March 2018 utilizing Antigen Immune Therapy, which utilizes injections of Patient B's urine, to treat Patient B's allergies. After Patient A filed a complaint, the board investigated respondent's care of both Patient A and Patient B. Cynthia Mervis Watson, M.D. testified at the hearing as the board's expert regarding respondent's care and treatment of Patient A and Patient B. She also wrote a report regarding her review and findings related to Patient A and Patient B, which was received in evidence. The following factual findings are based on Dr. Watson's testimony and related documents received in evidence.

13. Dr. Watson is in private practice as a family practice physician and has been licensed to practice medicine in California since 1986. Dr. Watson is board certified with the American Board of Family Practice and with the American Board of Integrated Medicine. Dr. Watson explained that she has in the past practiced naturopathic medicine, which is homeopathy and use of herbs and is sometimes called alternative medicine, complimentary medicine, or integrated medicine. Dr. Watson practices primarily in the field of family medicine generally, but she also currently utilizes alternative or integrated medicine with various treatments. She has been practicing alternative or integrated medicine since 1986. From 1986 to 1990 she worked for a large HMO group for one year, and thereafter she worked until 1990

providing primary care for an obstetrics and gynecology group. In 1990 she opened her own solo family practice office and has operated it ever since. Dr. Watson has served as a physician representative on the State of California Bureau of Naturopathic Medicine Advisory Council from October 2004 to June 2010. She explained that this council was formed by the State to standardize regulations for and to define the scope of practice for naturopaths as the State first started issuing licenses to practice as a naturopath. Dr. Watson has also worked as an expert reviewer for the board since 2000.

14. In addition to utilizing traditional medical treatment for her family medicine practice, Dr. Watson also utilizes various treatments such as supplements and intravenous vitamin therapies for nutritional purposes, immune system support, fatigue, and cancer treatment. Dr. Watson has utilized the "Meyer's cocktail" with her patients, which is a combination of vitamin C, vitamin B, and minerals developed by Dr. Meyer in an intravenous push to patients to treat fatigue, colds, viruses, and cancer. Dr. Watson was trained by Dr. Meyer himself in the late 1980s how to use this treatment. Additionally, Dr. Watson has also utilized "NAD" treatment, which is nicotinamide adenine dinucleotide treatment for chronic fatigue, and anti-aging. Dr. Watson explained that she has used NAD treatment by using it intravenously, topically, and orally in the form of a pill. Dr. Watson first became aware of intravenous NAD treatment (IV NAD) in the 1990s from Dr. Hitt, who practiced in Tijuana, Mexico. Dr. Watson explained that IV NAD is a similar treatment to the NeuroRecover program utilized by respondent for Patient A. Dr. Watson had never heard of the NeuroRecover program used by respondent until she was asked to review this matter.

15. Dr. Watson's review of respondent's care and treatment of Patient A involved her review of Patient A's complaint to the board, respondent's letter to the

board regarding his treatment of Patient A, certified medical records related to the treatment of Patient A by respondent as provide by the board, certified medical records for Patient A from the University of California San Diego (UCSD) emergency room visit, certified medical records from Dr. Bruce Hubbard, M.D., for treatment of Patient A, a report from the Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) regarding Patient A for reported transactions for dispensed controlled substance prescriptions, a brochure related to the NeuroRecover program provided to Dr. Watson by the board, and transcripts of telephone interviews of respondent.

16. Dr. Watson testified that Patient A, a 54-year-old man, first saw respondent on November 7, 2017, for advice on supplements and vitamins. Respondent diagnosed Patient A with candida overgrowth and put Patient A on a diet and supplement program. Patient A improved on the program and when he returned to respondent on December 5, 2017, for a follow-up appointment, respondent discussed the NeuroRecover program with Patient A. Specifically, Patient A had a long history of taking psychiatric medications and on December 5, 2017, was taking Cymbalta, Trazodone, and Clonazepam for depression, anxiety and PTSD and was being treated by a psychiatrist named Brian Hubbard, M.D., with whom he last visited in October 2017. Patient A had taken multiple psychotropic medications in the past, including taking Seroquil for 15 years, Clonazepam for two-and-a-half years, lithium and other drugs.

On the December 5, 2017, visit respondent documented that Patient A had been on psychiatric medications including lithium and Wellbutrin for 20 years, and respondent diagnosed Patient A with "toxic encephalopathy due to psych. meds." Dr. Watson testified that based on the information in Patient A's records, the toxic

encephalopathy diagnosis was not supported. Specifically, symptoms of toxic encephalopathy include mental confusion, loss of balance, and neurological complaints, none of which had been documented in Patient A. During this visit respondent recommended that Patient A undergo NeuroRecover treatment and informed Patient A that he could be taken off all of the psychotropic medications he was taking in a short period of time without withdrawal effects with the NeuroRecover program, which consists of daily intravenous administration of vitamins and amino acids. The initial treatment prescribed by respondent was for ten to twelve days of NeuroRecover treatment.

The first day Patient A received NeuroRecover treatment was on January 8, 2018. Respondent's medical notes for that day show that Patient A, who had been taking Cymbalta, Trazodone, and Clonazepam (these medications are benzodiazepines and antidepressants) up to that day, was still taking those three medications, but the dosage had been reduced for each. Dr. Watson explained that there was nothing in the medical records regarding the reduction of the dosage of those medications prior to the January 8, 2018, note, which was also the first day that Patient A received NeuroRecover treatment. The January 8, 2018, treatment consisted of a three-hour long intravenous infusion of a cocktail of various nutrients including vitamins B5, B6, B12, C, magnesium, calcium, and GSH. Dr. Watson explained that these nutrients are essentially the same as those that make up a Meyer's cocktail. Thereafter, Patient A continued to receive these NeuroRecover treatments daily until his final NeuroRecover treatment on January 29, 2018. During these treatments in January 2018, and as recorded in the medical records, Patient A complained of sleep disruption, mood swings, fits of crying, and increased anxiety and depression. Dr. Watson stated that Patient A did have a "few good days" during the NeuroRecover treatment, but generally his depression and anxiety worsened. On the medical record for the February

3, 2018, follow-up visit to respondent, Patient A reported that he felt suicidal, had "lots of anxiety" and "severe mental pain." Dr. Watson testified that this note shows that Patient A is having depression and anxiety symptoms again. However, respondent provided no differential diagnosis on why Patient A was experiencing symptoms again, and respondent provided no treatment plan to address those symptoms.

Dr. Watson explained that when a patient has been taking benzodiazepines and antidepressants for a long time, in order take the patient off those medications without experiencing withdrawal symptoms, also called rebound syndrome, you must slowly decrease the dosage of these medications over several months. If you take the patient off the medications too quickly, the rapid withdrawal will cause rebound withdrawal symptoms of depression, anxiety, sleep disturbance, agitation, nerve impulses and electrical shocks. Dr. Watson stated that she saw nothing in respondent's medical note for Patient A's February 3, 2018, visit or otherwise to indicate that respondent was considering rebound syndrome for the patient. Instead, on February 3, 2018, respondent diagnosed Patient A with mold toxicity. Dr. Watson stated that she saw no indication in the records that Patient A had any symptoms consistent with mold toxicity (such as respiratory symptoms, infectious sinusitis, cough, brain fog, fatigue, and recurring infections), and respondent did not obtain any mold toxin testing on Patient A.

Patient A's next visit to respondent was on February 21, 2018, and respondent noted in the medical records that Patient A had alternating sleep with one night getting sleep and the next not getting it, had anxiety starting at sunset, adrenal surges when he lies down, tingling that is painful all over his body, and "mental pain." Respondent also noted that "mold testing of house negative" meaning that there was no evidence of mold in Patient A's home. Dr. Watson stated that respondent's

assessment was that Patient A still had toxic encephalopathy from mold despite the fact that respondent never did any mold testing of Patient A and there was no evidence of mold or symptoms of toxic encephalopathy. However, Dr. Watson noted that Patient A was still experiencing symptoms of anxiety and depression over 20 days after completing the NeuroRecover treatment, but respondent failed to either recognize that problem or failed to provide any plan of treatment for it other than to recommend that Patient A move to a "high and dry climate" to deal with the mold issue. Patient A's February 21, 2018, visit to respondent was his last visit to respondent.

On March 20, 2018, Patient A went to the emergency room at UCSD with his chief complaint being depression, anxiety, insomnia, and suicidal ideations. A psychiatric attending physician, David Folsom. M.D., at UCSD evaluated Patient A and concluded that Patient A was suffering significant worsening of anxiety and depression as a result of abruptly being taken off all of his medications he had been taking for years to control his depression and anxiety. Patient A was discharged from the emergency room after being prescribed clonazepam. Thereafter, Patient A sought treatment with his psychiatrist, who started prescribing Celexa and Trazodone and slowly weaning Patient A off of clonazepam.

17. Dr. Watson opined that respondent's treatment of Patient A by taking him off of his medications, specifically the benzodiazepines he was taking, abruptly after Patient A had been taking them for years was an extreme departure from the standard of care. She explained that the standard of care requires that patients prescribed antidepressants and benzodiazepines require a gradual withdrawal (over a period of several weeks) from those medications under medical supervision in order to avoid withdrawal syndrome, which lead to a rebound of symptoms of depression. Dr. Watson noted that she believes that NAD therapy, which appears to resemble the

NeuroRecover program, can be a valuable treatment to assist with tapering a patient from taking benzodiazepines. However, there is not much in the literature or research regarding these treatments to do so and withdrawal from benzodiazepines can be complicated. Dr. Watson stressed during her testimony that she did not find any departures from the standard of care for respondent's use of the NeuroRecover therapy in and of itself. Instead, respondent departed from the standard of care by failing to recognize or to have a treatment plan for Patient A regarding Patient A's exhibited symptoms of rebound depression, anxiety and suicidal ideation as shown in the medical records from the January 29, 2018, February 3, 2018, and February 21, 2018, visits to respondent. Dr. Watson noted that respondent offered more NeuroRecover treatment for Patient A, but given Patient A's symptoms of rebound depression, anxiety and suicidal ideation, the standard of care requires that respondent provide some other treatment plan to address that issue. However, respondent failed to do so and thereby made a moderate to extreme departure from the standard of care by this failure.

18. With regard to Patient B, Dr. Watson testified that Patient A and Patient B are husband and wife. Patient B first saw respondent as a patient on February 9, 2018, and the medical records from that visit show that Patient B complained of sinus infection, allergies, a rash, and hearing loss. The medical records provided no information regarding any testing, history or exam related to Patient B's allergies. Respondent suspected that mold was the cause of Patient B's problems. Respondent recommended a treatment plan for Patient B's allergies consisting of Antigen Immune Therapy (AIT), which consists of intramuscular injections of Patient B's own urine. Dr. Watson is familiar with AIT, which is "definitely an alternative medicine" therapy. Dr. Watson explained that AIT involves collection of the urine from the patient, filtration of the urine to remove bacteria, then injection of the urine with the addition of lidocaine

back into the patient intramuscularly. She stated that the purpose of the injections is to "act like a vaccine" and it is a "desensitization treatment."

Patient B received a total of five urine injections with progressively increasing volumes of urine (from three ml on the first visit to nine ml on the last) injected at each of the five visits Patient B made for the injections. Patient B received the first injection on February 9, 2018, and her last of the five injections on March 8, 2018.

Dr. Watson testified and wrote in her report that there is nothing in Patient B's medical records documenting that respondent discussed the AIT treatment, the protocol for the AIT treatment, or the risks and possible side effects of the AIT treatment with Patient B prior to the injections. Dr. Watson stated that there was no "informed consent" in Patient B's medical records documenting that respondent informed Patient B of the risks, possible side effects, or other possible treatment alternatives as required by the standard of practice for physicians.

19. Dr. Watson opined that respondent's failure to obtain informed consent from Patient B and to document that informed consent in the medical records for Patient B constitutes a simple departure from the standard of care.

THE VACCINE EXEMPTION CASES

20. Patients C, D, E, and F are all pediatric patients, who were students in the SDUSD, and who received vaccination exemptions issued by respondent so that they may attend school without first obtaining required vaccinations. The board provided the testimony of its expert witness, Dean Abrams Blumberg, M.D., regarding his opinion that respondent committed an extreme departure from the standard of care for each of the four patients by issuing permanent vaccination exemptions to each of the patients without appropriate cause and without following the required medical

guidance. Dr. Blumberg wrote a report summarizing his findings, which was received in evidence. The following factual findings are based on his testimony and supporting documents received in evidence.

21. Dr. Blumberg has been licensed in California as a physician since 1987. He specializes in pediatric infectious disease. Dr. Blumberg obtained his M.D. degree in 1984 from the Chicago Medical School. He completed an internship in pediatrics in 1985 at Massachusetts General Hospital. Thereafter, he completed his residency in pediatrics in 1987 at Massachusetts General Hospital. Dr. Blumberg finished his fellowship in pediatric infectious disease in 1990 at the University of California, Los Angeles. Dr. Blumberg is board certified in both pediatrics and pediatric infectious disease from the American Board of Pediatrics. Dr. Blumberg is currently an Associate Professor of Pediatrics at the University of California Davis Children's Hospital (UCDCH), Division of Pediatric Infectious Diseases, Allergy & Immunology, a position he has held since 1996. Additionally, since 2008 and currently, he is the Chief of the UCDCH, Division of Pediatric Infectious Diseases, Allergy & Immunology. Dr. Blumberg is also currently the Chair of the Infection Control Committee of Shriner's Hospital for Children, Northern California, a position he has held since 1997. Dr. Blumberg is currently the Chair of the Infection Prevention Advisory Council of Shriner's Hospital for Children, a position he has held since 2000. In addition to all these positions, Dr. Blumberg is currently a member of multiple committees, subcommittees, advisory boards at UCDCH and at the University of California Davis Medical Center. In his current duties at UCDCH include direct patient care for both inpatients and clinic outpatients; teaching medical students, pediatric residents, and undergraduate students; administrative duties. Dr. Blumberg's duties at Shriner's Hospital includes direct patient care for pediatric patients, provides consulting work regarding infectious diseases, and administrative work. Dr. Blumberg also currently treats pediatric patients

at another community hospital in Sacramento one to two times every five weeks. Dr. Blumberg's patients consist of pediatric patients with a variety of infectious disease issues. Dr. Blumberg has also conducted extensive research over the past 30 years related to vaccines for their efficacy and safety. Dr. Blumberg spends approximately 40 percent of his time providing patient care.

In addition to his work above, Dr. Blumberg has repeatedly testified for the State of California legislature regarding immunization and immunization policies related to various legislation and regulations related to immunization. He repeatedly testified at the State of California legislature regarding immunization exemptions related to recent legislation that tightened immunization exceptions for school children by eliminating a parent's "personal belief" exemption to vaccinations and requiring parents obtain a vaccine exemption from a physician only when medical reasons for the exemption warrant it. Dr. Blumberg has testified for the board in various cases as an expert since 2018.

22. Dr. Blumberg testified that immunogenicity of a vaccine means the ability of the vaccine to induce an immune response. A vaccine with a higher immunogenicity creates a larger immune response from the patient, which provides better protection. However, there is a balance that is necessary because you want the maximum protection from the pathogen but a minimum of reactions to make sure the patient tolerates the vaccine. Dr. Blumberg opined that the standard of care for a physician to properly issue a vaccine exemption to a child patient is set forth in the American Academy of Pediatrics "Red Book" (red book) that sets out the general standards for immunization and contraindications for the administration of vaccines. He stated that the Centers for Disease Control (CDC) also provides standards related to the administration of vaccines in the United States. Dr. Blumberg stated that the CDC

guidelines apply to both adults and children, whereas the red book guidelines apply only to pediatric patients for childhood vaccines. Dr. Blumberg opined that these two sources set forth the standard of care for physicians in the United States for when a vaccine exemption should be issued, and the scope of the vaccine exemption issued. Both sources set out specific and general contraindications specific to each vaccine. He explained that a contraindication for a vaccine may be a serious allergic reaction to a component of the vaccine. In such cases the benefits of the vaccine must be weighed against the risk of administration. This risk/benefit analysis must be considered in each case. However, if the red book provides that there is a contraindication to the administration of a specific vaccine to a pediatric patient, then the standard of care requires that the physician not administer that vaccine to that patient. In addition to contraindications, the red book provides precautions for specific vaccines in certain circumstances. For example, for some patients the vaccine may not work as well because of an immunodeficiency in the patient, which would change the risk/benefit analysis. He explained that precautions are a far less serious concern than contraindications are.

Dr. Blumberg also opined that a simple departure from this standard of care would occur if a physician did not follow the guidance as set forth in the red book or CDC guidelines or made a simple error in doing so. By comparison, an extreme departure from the standard of care would occur if a physician simply created his or her own guidance rather than relying on the red book or CDC guidelines or deviates from the guidelines to an egregious degree.

23. Dr. Blumberg reviewed each of the vaccine exemptions issued by respondent to Patients C, D, E, and F; the certified medical records for each of these patients from respondent's practice, other than for Patient F for whom no records were

produced because respondent's office certified that no such records exist for Patient F; and respondent's written statement regarding his issuance of vaccine exemptions for each of these four patients.

With regard to the vaccine exemption issued by respondent for Patient C, Dr. Blumberg explained that the document has a list of vaccines in a left-hand column with boxes next to each listed vaccine. There are a total of seven listed vaccines on the form, which are Polio, DTaP (referring to diphtheria), MMR (measles, mumps, and rubella), HIB (haemophilus influenza type B), Hepatitis B, Varicella, and Tdap (tetanus, diphtheria, and acellular pertussis for adolescents). Respondent placed a check mark next to each of these seven listed vaccines, all of which are required for entry in school in the State of California. Respondent noted for each of these seven vaccines that the exemption issued was temporary until November of 2029. Notably, Patient C's date of birth is in November 2011, meaning that the vaccine exemptions respondent issued for Patient C expires when Patient C turns 18 years old. There is nothing on the vaccine exemption form to indicate why Patient C was issued the vaccine exemptions with no medical condition or circumstance that would justify the exemptions.

Dr. Blumberg reviewed the medical records of Patient C from respondent's practice for a determination of whether there was a medical reason to issue the vaccine exemptions. The medical records show that Patient C suffered from eczema, allergic urticaria, rhinitis, obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), candida, and insomnia. Dr. Blumberg also reviewed respondent's written response to the board regarding his reason for issuing the exemption to Patient C, which provided that respondent did so because he considers "immune disorders/hypersensitivity and mental/emotional stability" as valid reasons to issue the exemptions. Dr. Blumberg opined that none of the listed conditions in

Patient C's medical records or those listed in respondent's written response to the board are contraindications for any of the seven listed vaccines for which he gave an exemption. Dr. Blumberg stated that none of those are valid reasons for issuing a vaccine exemption under the applicable standard of care.

24. With regard to Patient D, the vaccine exemption issued by respondent is the same form as that used for Patient C with the same seven vaccines with boxes next to each of them checked to indicate that Patient D has been issued an exemption from receiving each of the seven vaccines. However, the vaccine exemption for Patient D shows that each of these seven vaccines also has a box on the right-hand column adjacent to each of the seven vaccines checked to indicate that the vaccine exemption issued for each vaccine is a permanent exemption rather than temporary exemption. Respondent provided no medical condition or circumstance on the form that would justify the exemptions.

Dr. Blumberg reviewed the medical records of Patient D from respondent's practice for a determination of whether there was a medical reason to issue the vaccine exemptions. The medical records show that Patient D suffered only from allergic rhinitis. Dr. Blumberg also reviewed respondent's written response to the board regarding his reason for issuing the exemption to Patient D, which provided that respondent did so because Patient D had a family history of adverse vaccine reactions. Dr. Blumberg explained that pursuant to the standard of care, neither allergic rhinitis or a family history of adverse vaccine reactions is a contraindication to any vaccine, and the red book explicitly states that a family history of adverse reactions to vaccines is not a contraindication to all vaccines. Dr. Blumberg also noted that Patient D's medical records from respondent were devoid of any information regarding Patient D's family history of adverse reactions to vaccines.

25. With regard to Patient E, there are two vaccine exemption forms issued by respondent. The first vaccine exemption dated August 28, 2017, is the same form as that used for Patients C and D with the same seven vaccines with boxes next to each of them checked to indicate that Patient E has been issued a temporary vaccine exemption from receiving each of the seven vaccines until July 12, 2026, which happens to be Patient E's 18th birthday. On this first vaccine exemption form for Patient E, respondent provided in the comment section, "various immune conditions, family history." Notably, the second vaccine exemption for Patient E issued by respondent dated December 3, 2018, which is on the same form as the August 28, 2017, exemption, was not issued on a temporary basis at all but was issued as being a permanent exemption to all seven vaccines, and no explanation was provided on the form. Dr. Blumberg testified that as noted above, a family history of adverse reactions to vaccines is not a contraindication to vaccines as set forth in the red book. With regard to the "various immune conditions" he stated it depends on what those conditions are, and for example if it consisted of a weakened immune system, then that could be a contraindication to certain vaccines (not all vaccines). However, a weakened immune system would not be a contraindication to any vaccine until the age of 18 or permanently.

Dr. Blumberg reviewed the medical records of Patient E and noted that Patient E is the biological sister of Patient D. The records disclose that Patient E suffered from bronchitis, asthma, allergic rhinitis, allergic urticaria, peanut allergy, depression, ADHD, obesity, candida enteritis, and insomnia. Dr. Blumberg explained that none of these listed conditions are contraindications for childhood vaccines, and none are valid reasons to qualify for a vaccine exemption under the applicable standard of care. Respondent's written response to the board regarding the reasons he provided a vaccine exemption for Patient E stated that the reason was that Patient E's siblings had

"severe adverse reactions when following the recommended vaccine schedule." Dr. Blumberg again opined that the standard of care for issuance of vaccine exemptions is, as set forth in the red book and the CDC, that family history of adverse reaction to vaccines is not a contraindication to vaccines.

26. With regard to Patient F, the vaccine exemption issued by respondent is the same form as that used for the other three patients above exempting the same seven vaccines. Patient F's vaccine exemption is a temporary exemption that expires on Patient F's 18th birthday. The vaccine exemption document provided no information regarding the reason for the issuance of the exemption. Dr. Blumberg testified that he had no medical records to review for Patient F because respondent's practice certified that no such medical records exist. Accordingly, Dr. Blumberg stated it is not clear if the patient had any medical reason for the issuance of the vaccine exemption. However, Dr. Blumberg opined that for each of the four vaccine exemption patients, including Patient F, there is no valid reason to issue a vaccine exemption either permanently or until the age of 18 for all vaccines listed on the form.

27. Dr. Blumberg considers a vaccine exemption issued for a child until that child's 18th birthday to be essentially a permanent exemption for childhood vaccines because at the age of 18 the patient is legally an adult and not subject to childhood vaccines thereafter. He opined that for all four vaccine exemption patients, respondent's issuance of these exemptions constituted an extreme departure from the standard of care. Dr. Blumberg stressed that it is important that vaccine exemptions only be issued to those children who really qualify for the exemptions because childhood vaccines are critical to protect children from vaccine-preventable diseases that may kill or can cause brain damage.

Dr. Blumberg further explained that there is no valid reason to provide a permanent vaccine exemption for all childhood vaccines for any particular patient and to do so is an extreme departure from the standard of care. He stated that there are some children with underlying immune conditions, such as conditions associated with immune deficiency or patients undergoing chemotherapy for cancer treatment whose immune systems are compromised, to whom you may not want to give specific vaccines, such as live virus vaccines, but those patients may still receive inactivated vaccines. Accordingly, those patients may qualify for a permanent exemption to vaccines containing live virus only, they do not qualify for a vaccine exemption to all childhood vaccines. Another example is a child with severe combined immune deficiency (SCID), a group of rare genetic disorders that are typically fatal within the first year or two after birth without immune-restoring treatment (sometimes called the "boy in the bubble" cases), who may not respond to any vaccine. In those cases, the child would receive a bone marrow transplant as an immune-restoring treatment and thereafter may receive vaccines. In those cases, the vaccine exemption to all childhood vaccines would only be temporary until the bone marrow transplant is received. Dr. Blumberg opined that there is no legitimate circumstance pursuant to the standard of care where any child should receive a permanent exemption (or exemption until the age of 18) to all childhood vaccines. Respondent's issuance of each of these four vaccine exemptions constitutes an extreme departure from the standard of care because respondent completely failed to adhere to the standard of care set forth in the red book or CDC guidelines.

Respondent's Evidence

28. Respondent testified at the hearing, as well as provided five witnesses, four of whom had been respondent's patients, and one was the mother of a patient, treated by respondent.

RESPONDENT'S TESTIMONY

29. Respondent is 60 years old and currently employed at Emerald NeuroRecover in Carmel, Indiana, where he has lived and worked for the past three-and-a-half years. Respondent is the Medical Director of Emerald NeuroRecover, which provides "primary care, functional medicine, and addiction treatment" according to his curriculum vitae. Respondent testified that he has no intention of ever moving back to California to live. Prior to working at Emerald NeuroRecover, respondent worked at the Center for Health and Wellbeing (CHW) in San Diego, California for eight-and-one-half years. He began working at CHW in August of 2010 after he had worked at the William Hitt Center in Tijuana, Mexico from 2003 to 2010. Prior to that he was in the United States Navy and worked from 2000 to 2003 as the Head of the Department of Outpatient Medicine at the U.S. Naval Hospital in Keflavik, Iceland. Respondent has been licensed to practice medicine in California since 2003, and he has been licensed to practice medicine in Indiana since 2018.

In addition to his work in Indiana, respondent currently is the Medical Director of SoCal Regenerative Medical Clinics located in West Covina, California, a position he has held since 2018. According to his curriculum vitae, the SoCal Regenerative Medical Clinics is "primarily treating joint degeneration with injection therapies." On cross-examination, respondent admitted that he is the owner of the SoCal Regenerative Medical Clinics. Additionally, on his curriculum vitae respondent provided that he

currently, and since 2012, has worked as a "Physician Consultant for AnazaoHealth training practitioners on the NeuroRecover intravenous NAD/amino acid treatment for neurological damage from drugs, alcohol, and medications." On cross-examination respondent admitted that AnazaoHealth is the company that supplies the NeuroRecover intravenous infusion products.

30. Respondent testified about his care and treatment of each of the seven patients at issue in this matter. With regard to Patient A, who was 54 years of age, respondent first saw Patient A on November 7, 2017, and met with Patient A for about one hour and 20 minutes that day. Respondent obtained Patient A's medical history and complaints during that visit. Patient A complained of depression, anxiety, chronic fatigue syndrome, and PTSD. Patient A also wanted respondent to "check for candida overgrowth and allergies." Patient A also complained of sleeping problems, muscle aches, diarrhea, dizziness, athlete's foot, sensitivity to sound and light, and toenail fungus. Patient A had a 30-year history of alcohol consumption and had stopped drinking alcohol within that year, and Patient A had a history of chlorine exposure from swimming a lot in his youth that resulted in multiple ear infections. Respondent obtained a list of all medications Patient A was taking and his psychoactive substance exposure history. After his physical examination of Patient A, respondent diagnosed him with toxic encephalopathy (which could be from prescription medication or alcohol exposure), excess candida growth, anxiety, insomnia, migraines, erectile dysfunction, and allergic rhinitis. Respondent treated Patient A with a "candida program," which is a three step anti-fungal program, and discussed the possibility of starting the NeuroRecover treatment program as a mechanism to get Patient A off his medications (antidepressants and benzodiazepines) which he had been taking for many years.

31. Respondent explained that the NeuroRecover treatment program is considered an intravenous nutritional therapy, which is not evaluated by the Food and Drug Administration (FDA), and it is based on IV use of NAD. IV NAD has been used since the 1970s and Dr. William Hitt added amino acids to the formula. The NeuroRecover treatment was created by Dr. Hitt and another individual. Respondent worked with Dr. Hitt in the William Hitt Center in Tijuana, Mexico from 2004 to 2010, and Dr. Hitt trained respondent on the use of NeuroRecover. Respondent considers himself an expert on NeuroRecover treatment, and he stated that he has treated more patients with NeuroRecover program than anyone else in the world. Respondent testified that the NeuroRecover treatment program assists with repair of neurological tissue and has shown consistent improvement for patients with substance abuse issues, such as alcohol, narcotics, nicotine, stimulants etc. Respondent has been using the NeuroRecover treatment for 18 years in approximately 600 patients with about 15 to 20 percent of those patients having "benzodiazepine involvement." Respondent stated that he has lots of years of observing how NeuroRecover treatment works, and its overall effect is that a person can withdraw from substances in a much shorter time with less intense withdrawal symptoms than if they have no NeuroRecover treatment at all. Respondent stated that it is "the rare individual who has a different experience." The goal of NeuroRecover treatment is "to get off the substances and also to restore the body." During cross-examination, respondent admitted that there has never been any published peer reviewed data regarding the efficacy of NeuroRecover for use to treat addiction.

Respondent testified that during the time he practiced in California, the cost of the NeuroRecover treatment was $300 per day for a patient with insurance, which was a deposit towards the patient's responsibility after copay, coinsurance, or deductible. For a patient without insurance the cost of NeuroRecover treatment in California was

between $600 to $700 per day. Respondent testified that currently the cost in Indiana is a "higher market price" of about $1,100 to $1,200 per day for a full eight-to-nine-hour day of IV infusion.

32. Respondent testified that Patient A showed improvement in the candida program and during his second visit to respondent on December 5, 2017, Patient A was counseled on the NeuroRecover program as a way to "get him off the medications" he was taking. Patient A agreed to undergo the NeuroRecover treatment and had his first IV infusion as part of that treatment on January 8, 2018. In preparation for this first day of treatment, Patient A had reduced his Cymbalta medication from 60 mg to 30 mg. Respondent testified that he "tapered" Patient A off of his medications prior to the NeuroRecover treatment, but he does not recall how, and he made no recordation of that tapering or when Patient A stopped taking his medications in the medical record. Respondent testified that he requires all of his patients to be completely off all of their medications by day three of the NeuroRecover treatment, and usually by day one of the treatment, because otherwise the NeuroRecover treatment simply does not work. As a result, respondent stated that typically day two and day three are the most difficult days for the treatment.

Thereafter, Patient A had daily IV infusions for the NeuroRecover treatment for 15 straight days. Respondent stated that during that time Patient A showed improvement in his depression and anxiety symptoms, had better sleep, and less sensitivity to stimuli. Respondent admitted that Patient A still had some depression and anxiety symptoms, including crying a lot during the first few days of treatment. Patient A then had his first day off between NeuroRecover treatments prior to day 16 of IV infusion on January 25, 2018. Thereafter, Patient A had "a day off here and there" from his IV infusion NeuroRecover treatment. On day 19 of his NeuroRecover

treatment on January 29, 2018, Patient A reported feeling better that day than he has in three weeks. Respondent testified that this day was "where we take a turn," and that Patient A felt he may be done with NeuroRecover treatment, which respondent stated was a "mutual decision." Respondent stated that there comes a time when NeuroRecover is not needed because it is not a perpetual program, but that is a "clinical judgment." The day 19 treatment on January 29, 2018, was Patient A's last NeuroRecover treatment.

Patient A's next visit to respondent was on February 3, 2018. During this visit Patient A reported to respondent that he was feeling suicidal at night, had lots of anxiety, insomnia, trembling legs, and severe mental pain. Respondent testified that "at this point I noticed that he was not having the outcome that I would expect from the improvement he once had." Respondent stated that "what was happening here was unexpected." Respondent stated that he "was wondering what was happening," and this time frame was the "rainy season" in San Diego, and that Patient B (Patient A's wife) told him that she suspected mold in their current apartment where they live. As a result, respondent suspected that mold was the cause of Patient A's new symptoms. Patient B also had symptoms of mold problems such as a rash, severe headaches, and sinus infection, and like Patient A, both had more severe symptoms at night. Respondent testified that Patient A had completed NeuroRecover treatment and was having difficulty paying for the portion not paid for by insurance. As a result, respondent did not want to commit them to further NeuroRecover treatment for Patient A and also "because it seemed like something else was going on." Respondent stated that he "followed the logical plan" and changed Patient A's candida program to treat the "mold illness" he suspected. Respondent discussed mold testing with Patient A and Patient B for their apartment and mold remediation and depression/insomnia management.

Patient A's next visit to respondent was his last visit to respondent on February 21, 2018. On this visit Patient A reported to respondent that his sleep is alternating with one night good and the next not, his anxiety starts at sunset, he has adrenal surges when he lays down, has painful tingling all over his body, has mental pain, has soreness, stiffness, tingling and tightening, and is very chemically sensitive. Patient A also reported to respondent that the mold testing of his home gave a negative result. Respondent testified that he was trying to figure out the cause of Patient A's symptoms and stated, "I am trying to figure out if it was because he was coming off his medications, or PTSD, or something else like mold, it was not clear." Respondent stated that Patient A's symptoms of soreness and stiffness, as well as feeling good in the afternoons and not good at night, was not typical of withdrawal symptoms from benzodiazepines. Respondent's treatment plan for Patient A was a possible booster day of NeuroRecover infusion if Patient A wanted it, nutritional supplements to help with chemical sensitivity, and a trial of leaving his home for two to three days to go to the high desert or a dry climate to treat possible mold. According to respondent, Patient A did not want to undergo another NeuroRecover treatment because of the financial cost involved. Respondent testified that the "trajectory of [Patient A] did not suggest that his symptoms" on February 3, 2018, and February 21, 2018, were indicative of benzodiazepine withdrawal, but respondent admitted that "this was a possibility," and that is the reason why respondent offered another booster NeuroRecover intravenous therapy. Instead, respondent testified that he believed candida was "a major source" of Patient A's anxiety. Respondent recommended that Patient A "go to a high and dry climate to see what was going on," and rule out mold as a cause of the symptoms. Patient A cancelled all of his future appointments after this one, and respondent was unable to "figure out" what was going on as a result.

Respondent insisted that he followed the standard of care with Patient A and followed the scientific evidence on how NeuroRecover treatment works. Respondent believes today that the cause of Patient A's anxiety and depression as of February 21, 2018, was likely because of mold or candida, but admitted that there "was a chance" it was because of withdrawal from antidepressant and benzodiazepine medications. Respondent believes that the NeuroRecover treatment for Patient A was successful as of February 21, 2018, but Patient A failed to follow up with respondent's recommended treatment after that date. In his current practice respondent utilizes NeuroRecover treatments as a way to take patients off of antidepressants and benzodiazepines.

33. With regard to Patient B, respondent only saw Patient B on one occasion for a formal appointment on February 9, 2018. On all other occasions respondent met with Patient B only when she accompanied her husband (Patient A) to his appointments. Respondent testified that on February 9, 2018, he interviewed Patient B to obtain her complaints, and her medical history, as well as performed a physical examination. Respondent spent 50 minutes with Patient B during this appointment. Patient B had complaints of allergies, a rash, and sinus headaches. Her first sinus infection happened in the Ohio River Valley and she suspected mold in her apartment. Her symptoms were worse at night. Respondent recommended a candida program for Patient B, as well as AIT, which consists of intramuscular injections of Patient B's own urine. Respondent testified that he thoroughly explained the AIT therapy to Patient B, including how it works and what is expected. Respondent stated that AIT therapy is a novel therapy, and because people are not used to the novel benefit of urine, so the therapy requires some explanation to all patients. He informed her that the AIT therapy is an eight-week treatment. Respondent does not himself inject the urine, but that task is instead done by the nurse practitioner. Respondent explained that while it

is the "clinic's policy" to have all patients receiving any kind of injection sign an informed consent document, that task is normally done in the clinic by medical assistants and nursing staff, but not him. Respondent admitted that he did not see any informed consent document for the AIT therapy for Patient B, and also saw no signed informed consent document for Patient B in either of their medical records from CHW. Respondent argued that the document may simply not have been produced by CHW. However, respondent also admitted that despite being aware of these allegations since at least December of 2020, he never bothered to subpoena those documents directly from CHW if he believed that the production of documents given to the board was incomplete. Regardless, respondent insisted that he completely informed Patient B of the AIT therapy.

34. Respondent also testified about each of the four vaccine exemption patients. Respondent also wrote a letter summary dated March 2, 2022, regarding his treatment and issuance of a vaccine exemption for each of the four patients, which was received in evidence.

35. Respondent testified that Patient C was a seven-year-old girl when he issued the vaccine exemption and he had treated her for "a few years." He noted in the medical records and in his letter to the board that Patient C suffered from OCD, eczema, oppositional-defiant disorder, ADHD, insomnia, and allergic urticaria. Respondent had treated Patient C with diet and supplements and most of her conditions improved after months of treatment, and respondent considered Patient C to be "a fragile patient." Respondent testified that Patient C's parent requested a vaccine exemption, and respondent was "concerned because [Patient C] was highly allergic to the point of hives," and Patient C had "some metabolic conditions that caused these emotional disorders." Respondent stated that it was his decision to grant

the vaccine exemption "knowing that she had taken quite a while to improve, and I considered her a vulnerable patient." In his letter to the board respondent wrote that he granted the vaccine exemption, "at the parent's request, weighing the patient's overall medical condition, especially immune disorders/hypersensitivity and mental/emotional stability, vs. the benefits of the vaccine."

36. Patient D and Patient E are siblings, with Patient D being the younger sister (six years old at the time the exemption was issued) to Patient E (ten years old at the time the exemption was issued). Patients D and E are two of five siblings. According to respondent, the three other siblings are older, and as reported by their mother, "had significant adverse reactions when they followed the recommended vaccination schedule," and as a result, all of those three children obtained a vaccination exemption from another physician. Respondent admitted that he was not aware of any specific vaccine that caused any adverse reaction in those children, and that he had never met those other three children. Respondent testified that Patient D had allergic rhinitis, irritable bowel syndrome, persistent fatigue, and mood disorder. He stated that both Patient D and Patient E had mood disorders at "pretty young ages, which I find to be caused by a metabolic disorder." Respondent stated that for Patient D he was worried about "chronic infection and undiagnosed viruses, which is an immune issue." Patient E had asthma, allergic rhinitis, ADHD, peanut allergy, depression, irritable bowel syndrome, obesity, allergic urticaria, recurrent sinusitis, and eosinophilia. Patient E had excessive immune reactivity with a number of allergic syndromes, which respondent considered to be a complex health condition. Respondent testified and wrote in his letter that for both Patient D and Patient E, their complex immune issues coupled with the strong family history of adverse reactions to vaccines was the reason he agreed to issue the vaccine exemptions for both Patient D and E as requested by their parent.

37. With regard to Patient F, respondent had no recollection whatsoever of issuing that vaccine exemption to Patient F, and no patient records regarding Patient F were produced. However, respondent admitted that it was his signature on the vaccine exemption issued for Patient F. Respondent testified that he is not anti-vaccine and that "the concept of vaccines is important." His practice in California consisted of "maybe two to three percent of patients seeking vaccine exemptions." Respondent stated that the vaccine exemption forms he used had a comment section for use to put the reason for the issuance of the vaccine exemption, but there was no mandate to do so. He stated that the reason for the exemption "needs to be" in the patient's medical records, but he did not always write his reasoning for issuance of the vaccine exemption in those records. Respondent stated that for each of the four patients at issue in this matter he "gave the vaccine exemption because I have a history on these kids."

38. Respondent asserted that the standard of care regarding the issuance of vaccine exemptions is not set forth in the red book or CDC guidelines, even though those sources are "well written for a check list for childhood vaccinations," but don't provide guidance on the issuance of vaccine exemptions. Respondent stated that the issuance of vaccine exemptions "was never covered in his training," and he relies on his own judgment on whether to issue the exemptions after taking into account the risk/benefit analysis. Respondent stated that with regard to the four children at issue, he felt as if he "would be inducing a highly probable event of a bad reaction" if those children were administered any vaccine.

39. Respondent also argued that, with regard to his prior license discipline of public reprimand in February 2019, he did not commit those acts as alleged, and he stated that he signed the settlement agreement that resulted in his license discipline

because he "did not understand the law." Respondent argued that he did nothing wrong with regard to the treatment of those patients in his underlying discipline, and if that accusation would be filed today, he would, "never be subject to that type of insult again."

TESTIMONY OF RESPONDENT'S PATIENTS

40. Respondent provided four witnesses, who had been or currently are his patients, to testify on his behalf regarding respondent's character. Additionally, respondent provided one witness, who is the mother of a patient treated by respondent, to testify on his behalf regarding respondent's character. The following factual findings are based on their testimony.

41. Ryan Steinbrecher is a 34-year-old registered nurse, who lives in San Diego, California. Mr. Steinbrecher testified that he was respondent's patient in 2017 at respondent's clinic in Carmel, Indiana, and received NeuroRecover treatment as a mechanism to stop his cigarette addiction. Mr. Steinbrecher stated that he was a one pack a day smoker for over ten years prior to the treatment, and respondent cured his cigarette smoking addiction with NeuroRecover treatment, and he has not touched a cigarette since. Mr. Steinbrecher reached out to respondent in Indiana because he knew a person who had been successfully treated by respondent for a 20-to-30-year addiction to alcohol. The last time Mr. Steinbrecher saw respondent was about one-and-a half years ago. Mr. Steinbrecher testified that respondent "has the highest integrity of any physician he has ever met," and is an addiction specialist with knowledge beyond any other physician he has ever met. Mr. Steinbrecher testified that he is aware that respondent is being charged with negligence and that his character is being challenged, but that he is not aware of any specific allegation against respondent. Mr. Steinbrecher wrote a letter to the board, which was received in

evidence, that mirrored his testimony. In the letter Mr. Steinbrecher wrote that "[w]however is making up these bogus accusations or slanderous claims against [respondent] . . . is an absolute liar." However, Mr. Steinbrecher admitted he does not actually know what the allegations against respondent are.

42. Randall O'Donnell is a 69-year-old furniture maker and contractor living in central Indiana. Mr. O'Donnell met respondent in May 2021 at respondent's Indianapolis, Indiana, clinic where Mr. O'Donnell became respondent's patient. In addition to being respondent's patient, Mr. O'Donnell and respondent have interacted socially, been to each other's homes, met each other's families, and gone boating together. Mr. O'Donnell has met with respondent about 16 times. Mr. O'Donnell came to respondent's clinic because of "cholesterol problems and aging." Mr. O'Donnell stated that respondent has "helped him turn back the clock" and now he "feels like I am 16 years old again." Mr. O'Donnell testified that respondent has a "sterling character," is a fine person and an excellent physician. He attributes his health and over-all wellbeing to respondent. Mr. O'Donnell has not seen the accusation in this matter or reviewed any evidence. However, he stated that he "was told about" this matter.

43. Karen Marrow is a 57-year-old physical therapist living in Las Vegas, Nevada. Ms. Marrow is the mother of a young woman, who has been respondent's patient over the past seven years. Ms. Morrow's daughter first became respondent's patient in 2015 by telephone consultation, and first met respondent in 2017 in his clinic in San Diego. Ms. Marrow has seen respondent about six to eight times per year over the course of her daughter's treatment. Ms. Marrow first reached out to respondent in 2015 regarding her daughter because at that time her daughter, at the age of 17, "started to go crazy," was depressive, manic, and "had to be hospitalized

because she was out of control." As a result, Ms. Marrow's daughter was seen by many psychiatrists and put on multiple medications, which Ms. Marrow stated did not really solve the problems but gave her daughter many side effects. Her daughter would "talk to people who were not there," and would treat her parents like the enemy. Ms. Marrow was unable to successfully find help for her daughter until she met respondent, who was the first physician who had confidence he could treat her daughter, thereby giving Ms. Marrow hope. Ms. Marrow testified that through respondent, they learned that her daughter had lots of food allergies, is allergic to mold, and there were a lot of molds in their home. Ms. Marrow stated that "with respondent's help, we were finding out all the underlying factors as to why my daughter was going crazy." Pursuant to respondent's advice, Ms. Marrow changed her daughter's diet and they changed where they lived to move to a dry climate in Las Vegas in January 2020. Ms. Marrow testified that her daughter has not been hospitalized for two years, which is a record for her. Her daughter has her life back, goes on hikes, sleeps, and has an art business, and Ms. Marrow credits respondent with that. Ms. Marrow stated that respondent is a very knowledgeable and caring physician.

44. Mark Allen VandenBoom is a 48-year-old cybersecurity worker who resides in Indianapolis, Indiana. Mr. VandenBoom first met respondent six months ago when he became respondent's patient. Mr. VandenBoom reached out to respondent because Mr. VandenBoom had been reading about NAD treatments and was seeking an NAD provider. Mr. VandenBoom has seen respondent about five to six times and last saw him about one month ago. Mr. VandemBoom has never met respondent outside of respondent's clinic and has no personal relationship with respondent other than as his patient. Mr. VandenBoom has a complicated medical history and in 2014 had a series of surgeries, including the placement of abdominal mesh, which was in his

body for about three months and caused him to have burning, rashes, and "all kinds of trouble," including anxiety and brain fog. Mr. VandenBoom went to Germany to have two surgeries to have the mesh removed. Thereafter, Mr. VandenBoom became allergic to "lots of things including ibuprofen." Mr. VandenBoom had difficulty finding a physician in Indiana because of pending litigation he was involved in regarding the surgical mesh. Mr. VandenBoom found respondent who treated him like the complicated case he was, was very knowledgeable, was his partner in his healthcare, and restored his faith in the medical community. Ultimately, Mr. VandenBoom did not receive any NAD therapy from respondent because he did not recommend it and instead put him on a special diet that has helped tremendously and within two weeks of seeing respondent. Mr. VandenBoom has lost 40 pounds, is no longer diabetic, and no longer has a thyroid issue after seeing respondent. Mr. VandenBoom is not aware of the allegations in this matter.

45. Lara Minucci is a 53-year-old woman living in Hilton Head, South Carolina. In 2018 Ms. Minucci lived in San Diego, California and first met respondent in May 2018 at the CHW clinic when she became his patient. The last time Ms. Minucci saw respondent was in June 2018, and she has never met him outside of the clinic. Ms. Minucci first reached out to respondent because she had learned about NeuroRecover treatment on-line. At that time Ms. Minucci was suffering from akathisia, which is a state of agitation, distress, and restlessness that is a side-effect of antipsychotic and antidepressant drugs. Ms. Minucci had been taking antidepressant drugs and benzodiazepines for about 30 years and started to develop a lot of agitation and panic, which was "something that felt chemical to me," and started to become suicidal. Ms. Minucci had been hospitalized and was seeking help to get off the medications. Ultimately, Ms. Minucci was treated by respondent with the NeuroRecover program every day for three-and-a-half weeks or about 25 days. When she started the

NeuroRecover program she felt unstable and when she finished, she was off all medications, was calm, and had no problems. She stated that this improvement has persisted and "as long as she takes no medications" she is fine. Ms. Minucci considers respondent to be a knowledgeable, caring, and kind physician, and feels as if she "struck gold" when she found him. Ms. Minucci is not familiar with the allegations in this matter.

Cost of Investigation and Enforcement

46. Complainant seeks recovery of enforcement costs of $30,743.75 pursuant to Business and Professions Code section 125.3. In support of the request, the Deputy Attorney General who prosecuted the case signed a declaration requesting costs for legal work billed through August 23, 2022, totaling $18,482.50. Additionally, the Deputy General who prosecuted the case signed a supplemental declaration requesting supplemental costs for legal work billed from August 25, 2022, to September 12, 2022, totaling $12,261.25. Attached to both declarations was a document entitled "Costs of Suit Summary." These documents identified the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate of the individuals who performed the work.

47. Complainant submitted a declaration of investigative costs in this matter signed by the special investigator for the board and attaching a form containing a general description of the tasks performed, the time spent on the tasks, and the hourly rate charged for the work of the special investigator. The certification of investigative costs submitted in this matter established that the board billed $1,638 for 15.75 hours expended on this case for investigation.

48. California Code of Regulations, title 1, section 1042, subdivision (b), requires that any declaration seeking costs include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." The certifications of enforcement and investigation satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certification regarding enforcement costs supports a finding that costs in the amount of $30,743.75 are reasonable in both the nature and extent of the work performed. The certification regarding investigation costs supports a finding that costs in the amount of $1,638 are reasonable in both the nature and extent of the work performed. Accordingly, the reasonable cost of enforcement and investigation of this matter is $32,381.75.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Statutes

2. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

3. Business and Professions Code section 2227 provides that a licensee who is found to have violated the Medical Practices Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay costs of probation monitoring, be publicly reprimanded, or such other action taken in relation to the discipline as the board deems proper.

4. Business and Professions Code section 2234, provides in 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:
>
> [¶] . . . [¶]
>
> (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. . . .

5. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

The Standard of Care, Gross Negligence, Simple Negligence

6. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

7. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

8. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

9. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

10. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra, at pp.* 1054.)

Disciplinary Guidelines

11. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines the board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the board and proposed settlements submitted to the board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the

disciplinary guidelines shall identify the departures and the facts supporting the departure.

12. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, and failure to maintain adequate medical records is a stayed revocation for five years. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend an education course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, a practice monitor, and solo practice prohibition.

Evaluation

13. Complainant alleged that respondent engaged in gross negligence with regard to his treatment of Patient A, as well as all four of the vaccine exemption patients. Complainant also alleged that respondent committed repeated negligent acts with regard to each of those patients above, as well as with Patient B. Complainant alleged that respondent failed to maintain adequate and accurate records for Patient B by failing to obtain and record informed consent for the AIT treatments. Complainant provided two expert witnesses to establish these allegations. The first expert witness, Dr. Watson, opined exclusively regarding respondent's care of Patient A and Patient B. The second expert witness, Dr. Blumberg, opined exclusively regarding the four vaccine exemption patients. Respondent provided no experts other than himself to counter the opinions of Dr. Watson and Dr. Blumberg. In determining the weight of each expert's testimony, the expert's qualifications, credibility, and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.) Both Dr.

Watson and Dr. Blumberg are eminently qualified in their respective fields, both testified credibly and in a forthright manner with sound reasoning underlying their opinions, and both had extensive knowledge of the standard of care applicable to the issues at hand based on years of experience. While respondent does have years of experience and training in his field, given that respondent has an obvious bias to protect his license, respondent's opinions are found less reliable than those of Dr. Watson or Dr. Blumberg.

14. With regard to the allegations related to Patient A, Dr. Watson credibly testified that respondent's use of the NeuroRecover treatment program itself was not a deviation from the standard of care and was an accepted alternative medicine therapy for various uses. However, she also opined that respondent did deviate from the standard of care to an extreme degree when he failed to taper Patient A's antidepressant and benzodiazepine medications over a period of weeks rather than abruptly over a couple of days thereby causing rebound withdrawal symptoms such as anxiety and depression. Dr. Watson further opined that while NAD therapies and NeuroRecover treatment may very well shorten the time period required to taper down the antidepressants and benzodiazepines, respondent failed to recognize on February 3, 2018, and February 21, 2018, that Patient A was suffering serious rebound withdrawal syndrome of anxiety and depression, including suicidal ideation. Instead, respondent admitted that he believes those symptoms were related to mold and suggested Patient A move to a dry climate. Dr. Watson's opinion that respondent's failure to recognize and provide an appropriate treatment plan for Patient A's rebound withdrawal syndrome is an extreme departure from the standard of care was more credible than respondent's opinion. Respondent opined that while it was possible that rebound withdrawal syndrome was a factor in Patient A's symptoms on those dates and after the NeuroRecover treatment, respondent continued to insist that mold was

the major factor and blamed Patient A for simply not following his recommendations. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with regard to his care and treatment of Patient A.

15. With regard to the allegations related to Patient B, complainant alleges that respondent committed negligence and unprofessional conduct by failing to obtain or document informed consent from Patient B for the AIT treatments. While respondent testified that he provided Patient B with oral information regarding the AIT treatments, he stated that it was his staff's responsibility to obtain the written informed consent from Patient B and he did not know if the staff actually did so. Respondent argued that the documentation of the informed consent may exist but was simply not produced. However, respondent never bothered to subpoena documents from CHW, and complainant provided a certification from the custodian of records from CHW that all documents related to Patient B were produced and there was no informed consent document in that production. Accordingly, complainant established by clear and convincing evidence that respondent failed to document informed consent of Patient B for AIT treatments, which is a simple departure from the standard of care and constitutes negligence, as well as constitutes unprofessional conduct under Business and Professions Code section 2266.

16. With regard to Patient C, Patient D, Patient E, and Patient F, complainant alleges that respondent committed gross negligence and repeated negligent acts regarding the issuance of vaccine exemptions related to these four patients. Dr. Blumberg credibly testified that respondent deviated from the standard of care as set forth in the red book and CDC guidelines to an extreme degree when he issued the four vaccine exemptions for these patients either permanently or until the child reached the age of 18 for all childhood vaccines. Dr. Blumberg explained that there is

no set of circumstances that would justify the issuance of a vaccine exemption for all childhood vaccines permanently or until the child reaches the age of 18, which is effectively permanently as the child would be considered an adult at that time. Dr. Blumberg has eminent qualifications as a pediatric infectious disease specialist and as a physician knowledgeable of the standard of care regarding childhood vaccines and the issuance of vaccine exemptions. As Dr. Blumberg established, none of the symptoms or conditions contained in the medical records for Patient C, Patient D, or Patient E are contraindications for any of the listed childhood vaccines on the vaccine exemptions issued by respondent. Furthermore, the medical records and the vaccine exemption documents for Patient C, Patient D, or Patient E provide no written explanations for the reasoning behind the issuance of the vaccine exemptions. With regard to Patient F, no medical records exist according to the custodian of records for CHW, and no reasoning was provided on the vaccine exemption document for the issuance of the exemption for all childhood vaccines. Respondent had no recollection of Patient F or treating Patient F. Regardless, as Dr. Blumberg credibly explained, there is no condition or circumstance within the standard of care that would justify the issuance of a permanent (or until the child reaches the age of 18) vaccine exemption for all childhood vaccines.

Respondent disagreed with Dr. Blumberg's use of the red book and CDC guidelines as establishing the standard of care for a physician with regard to issuance of vaccine exemptions. Respondent argued that it was within his discretion to issue a vaccine exemption if he feels it is appropriate and without reference to the red book and CDC guidelines. Respondent also claimed that those sources did not provide guidance with regard to a patient with multiple immune issues. Respondent also admitted during his testimony that he did not receive training on how and when to issue a vaccine exemption. Dr. Blumberg's testimony regarding the standard of care

for the issuance of vaccine exemptions was more credible that the testimony of respondent in that regard. Respondent admitted that he not only disregarded the red book and CDC guidelines in the issuance of these four exemptions, but simply substituted his own judgment for that guidance. Accordingly, as explained by Dr. Blumberg, respondent's choice to do so was an extreme departure from the standard of care constituting gross negligence and repeated negligent acts.

Cause Exists to Discipline Respondent's License

17. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in gross negligence with respect to his care and treatment of Patient A for failing to gradually reduce Patient A's antidepressant and benzodiazepine use over several weeks, failing to recognize that Patient A was suffering rebound withdrawal syndrome, and failing to provide appropriate treatment after Patient A's symptoms returned; and that respondent engaged in gross negligence with respect to his issuance of vaccine exemptions for Patient C, Patient D, Patient E, based upon his reliance on unsupported reasons for issuance of the exemption, based upon providing an exemption for all childhood vaccinations, and based upon his failure to have or document proper contraindications for all childhood vaccines; and that respondent engaged in gross negligence with respect to his issuance of vaccine exemptions for Patient F based upon providing an exemption for all childhood vaccinations, and based upon his failure to have or document proper contraindications for all childhood vaccines.

18. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to his

care and treatment of Patient A as noted above, his failure to maintain adequate and accurate records for patient B, and his issuance of vaccine exemptions for Patient C, Patient D, Patient E, and Patient F as noted above.

19. Cause exists under Business and Professions Code section 2266 to impose discipline. Complainant established by clear and convincing evidence that respondent maintained inadequate or inaccurate medical records with respect to Patient B by failing to obtain or properly document informed consent from Patient B for antigen receptor injections.

Application of Disciplinary Guidelines

20. Because cause for discipline exists, a determination of the degree of discipline necessary must be made with application of the Disciplinary Guidelines. Respondent has long history of providing medical care for over 19 years. Respondent provided testimony of four of his patients, and one parent of a patient, all of whom praised respondent's care, treatment, knowledge, and character as a physician. However, respondent also has prior disciplinary history on February 22, 2019, involving gross negligence, repeated negligent acts, and violations of the Medical Practice Act. That prior license discipline occurred only three years ago and involved the same general causes for discipline as in this matter, namely gross negligence and repeated negligent acts involving the treatment of his patients. Notably, during this hearing respondent provided no evidence to establish that he believes he has committed any of those acts, and even argued during the hearing that he did not commit the acts underlying his February 22, 2019, license discipline. Respondent has not undergone any self-reflection, takes no responsibility for his actions, and has made no changes to his practice as a result of that discipline. In this matter respondent again argued that he did not commit any of the alleged acts of gross negligence, repeated negligent acts

or failure to maintain adequate and accurate records. Respondent is again taking no responsibility for his actions. Furthermore, respondent currently lives and practices medicine in the State of Indiana, and he testified he has no intention of ever living in the State of California again. Accordingly, respondent would not be able to abide by any probationary terms, if any such terms were issued, because he does not live in California. This is even more of a concern because respondent owns and operates medical clinics in the State of California.

Under these circumstances and after consideration of all evidence provided, the only discipline that will provide public protection is revocation.

Cost of Investigation and Enforcement

21. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate 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." "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." (Bus. & Prof. Code, § 125.3, subd. (c).) The reasonable costs in this matter were $32,381.75.

22. The Office of Administrative Hearings has enacted a regulation for use when evaluating an agency's request for costs under Business and Professions Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulation, a cost request must be accompanied by a declaration or certification of costs. For services provided by persons who are not agency employees, the declaration must be executed by the person providing the service and describe the general tasks performed, the time spent

on each task, and the hourly rate. In lieu of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

23. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the Administrative Law Judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct.

24. Considering the *Zuckerman* factors, the scope of the investigation was appropriate to the allegations and the deputy attorney general who tried the matter was very well prepared. Respondent was not successful in getting the charges reduced or dismissed; respondent did appear to assert a good faith belief in the merits of his position; respondent did not raise a colorable challenge to the proposed discipline; and respondent failed to present any evidence that he is financially unable to pay costs. Accordingly, the costs of $32,381.75 are deemed reasonable, and respondent shall pay that amount to the board in the event he ever seeks reinstatement of his license.

ORDER

1. Physician's and Surgeon's Certificate number A83402 issued to respondent John Edward Humiston, M.D. is revoked.

2. If respondent's Physician's and Surgeon's Certificate is reinstated, respondent shall pay to the board the costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3, in the amount of $32,381.75. Respondent shall be permitted to pay these costs in a payment plan approved by the board. Nothing in this provision shall be construed to prohibit the board from reducing the amount of cost recovery upon reinstatement of the license.

DATE: January 12, 2023

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings