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

In the Matter of the First Amended Accusation Against: Margaret Aranda, M.D. Physician's and Surgeon's Certificate No. G 73982 Respondent.	Case No. 800-2019-060903

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 29, 2023.

IT IS SO ORDERED June 22, 2023.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Interim Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
MARSHA E. BARR-FERNANDEZ
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **MARGARET ARANDA, M.D.** **1536 South State Street, #211** **Hemet, CA 92543-4900** **Physician's and Surgeon's Certificate No. G 73982,** Respondent.	Case No. 800-2019-060903 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Interim Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Marsha E. Barr-Fernandez, Deputy Attorney General.

2. Margaret Aranda, M.D. (Respondent) is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

3. On or about May 5, 1992, the Board issued Physician's and Surgeon's Certificate No. G 73982 to Margaret Aranda, M.D. (Respondent). The Physician's and Surgeon's Certificate was

in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-060903 and will expire on June 30, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2019-060903 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 13, 2022; the First Amended Accusation and all other statutorily required documents were properly served on Respondent on November 4, 2022. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2019-060903 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in First Amended Accusation No. 800-2019-060903. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2019-060903, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

10. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician's and Surgeon's Certificate without further process.

RESERVATION

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

CONTINGENCY

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 73982, issued to Respondent MARGARET ARANDA, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2019-060903 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $34,198.25 (estimated costs) prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation, No. 800-2019-060903 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: June 5, 2023

MARGARET ARANDA, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: June 6, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

MARSNA E. BARR-FERNANDEZ
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-060903

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **MARGARET ARANDA, M.D.** **325 Rolling Oaks Drive, Suite 210** **Thousand Oaks, CA 91361** **Physician's and Surgeon's Certificate No. G 73982,** Respondent.	Case No. 800-2019-060903 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about May 5, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 73982 to Margaret Aranda, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

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

5. Section 2228 of the Code states:

> The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:
>
> (a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.
>
> (b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

7. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

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8. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

9. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

10. Section 2262 of the Code states:

Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

11. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

12. Section 2266 of the Code states:

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

13. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

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

14. Section 4170 of the Code states:

(a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the California State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the California Board of Podiatric Medicine, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the Osteopathic Medical Board of California, the California State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the California Board of Podiatric Medicine.

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15. Health and Safety Code section 11055 states, in pertinent part, as follows:

(a) The controlled substances listed in this section are included in Schedule II.

(b) Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

(1) Opium, opiate, and any salt, compound, derivative, or preparation of opium or opiate, with the exception of naloxone hydrochloride (N-allyl-14-hydroxy-nordihydromorphinone hydrochloride), but including the following:

...

(J) Hydromorphone.[1]

...

(c) Opiates. Unless specifically excepted or unless in another schedule, any of the following opiates, including its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of those isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrorphan and levopropoxyphene excepted:

...

(8) Fentanyl.[2]

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[1] Hydromorphone (Dilaudid®) is an opioid analgesic. When properly prescribed and indicated, hydromorphone is used for the treatment of moderate to severe pain. The Drug Enforcement Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Federal Drug Administration has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid® with benzodiazepines or other central nervous system (CNS) depressants.

[2] Fentanyl transdermal (Duragesic®) patches, when properly prescribed and indicated, are used for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

16. Health and Safety Code section 11056 states, in pertinent part, as follows:

(a) The controlled substances listed in this section are included in Schedule III.

...

(g) Ketamine.[3] Any material, compound, mixture, or preparation containing ketamine.

17. Health and Safety Code section 11158 states as follows:

(a) Except as provided in Section 11159 or in subdivision (b) of this section, no controlled substance classified in Schedule II shall be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section 11159 or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, no controlled substance classified in Schedule III, IV, or V may be dispensed without a prescription meeting the requirements of this chapter.

(b) A practitioner specified in Section 11150 may dispense directly to an ultimate user a controlled substance classified in Schedule II in an amount not to exceed a 72-hour supply for the patient in accordance with directions for use given by the dispensing practitioner only where the patient is not expected to require any additional amount of the controlled substance beyond the 72 hours. Practitioners dispensing drugs pursuant to this subdivision shall meet the requirements of subdivision (f) of Section 11164.

(c) Except as otherwise prohibited or limited by law, a practitioner specified in Section 11150, may administer controlled substances in the regular practice of his or her profession.

18. Health and Safety Code section 11164 states, in pertinent part, as follows:

Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name of the ultimate user

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[3] Ketamine is a dissociative anesthetic that has some hallucinogenic effects. It distorts perceptions of sight and sound and makes the user feel disconnected and not in control. It is an injectable, short-acting anesthetic for use in humans and animals. It is referred to as a "dissociative anesthetic" because it makes patients feel detached from their pain and environment. Ketamine can induce a state of sedation (feeling calm and relaxed), immobility, relief from pain, and amnesia (no memory of events while under the influence of the drug)...A couple of minutes after taking the drug, the user may experience an increase in heart rate and blood pressure that gradually decreases over the next 10 to 20 minutes. Ketamine can make users unresponsive to stimuli...An overdose of ketamine can cause unconsciousness and dangerously slow breathing. (*Drugs of Abuse, A DEA Resource Guide* (2020 Edition), p. 80.)

or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

...

19. Health and Safety Code section 11165[4] states, in pertinent part, as follows:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

...

(d) For each prescription for a Schedule II, Schedule III, Schedule IV, or Schedule V controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, 1308.14, and 1308.15, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the department or contracted prescription data processing vendor as soon as reasonably possible, but not more than one working day after the date a controlled substance is released to the patient or patient's representative, in a format specified by the department:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of a prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

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[4] The relevant parts of Health and Safety Code section 11165 in effect in 2019 and 2020 were substantially similar to the current version, with the relevant difference being that in 2019 and 2020, the reporting requirement in subsection (d) was seven days, rather than one working day, after the date a controlled substance was dispensed, rather than "released to the patient or patient's representative."

(6) The International Statistical Classification of Diseases (ICD) Code contained in the most current ICD revision, or any revision deemed sufficient by the State Board of Pharmacy, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Prescribing date of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

...

20. Health and Safety Code section 11165.1 states, in pertinent part, as follows:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances pursuant to Section 11150 shall, upon receipt of a federal Drug Enforcement Administration (DEA) registration, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to the practitioner or their delegate the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

...

(B) The department may deny an application or suspend a subscriber, for reasons that include, but are not limited to, the following:

...

(iv) Violating a law governing controlled substances or another law for which the possession or use of a controlled substance is an element of the crime.

...

21. Health and Safety Code section 11165.4[5] states, in pertinent part, as follows:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the patient activity report or information from the patient activity report obtained from the CURES database to review a patient's controlled substance history for the past 12 months before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the

[5] The relevant parts of Health and Safety Code section 11165.4 in effect in 2019 and 2020 were substantially similar to the current version, with the only substantive difference being that in 2019 and 2020, subsection (a) required a practitioner to review a patient's controlled substance history every four months, instead of every six months.

patient for the first time and at least once every six months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

...

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in their role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall review a patient's controlled substance history that has been obtained from the CURES database no earlier than 24 hours, or the previous business day, before the health care practitioner prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

...

(d)(1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

...

22. Health and Safety Code section 11171 states as follows:

No person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

23. Health and Safety Code section 11190 states as follows:

(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

(1) The name and address of the patient.

(2) The date.

(3) The character, including the name and strength, and quantity of controlled substances involved.

(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

(c)(1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

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(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(C) NDC (National Drug Code) number of the controlled substance dispensed.

(D) Quantity of the controlled substance dispensed.

(E) ICD-9 (diagnosis code), if available.

(F) Number of refills ordered.

(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(H) Date of origin of the prescription.

(2)(A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

(d) This section shall become operative on January 1, 2005.

(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

COST RECOVERY

24. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the

administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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

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

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

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

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

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

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

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

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

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FACTUAL ALLEGATIONS

25. Respondent is a Board-certified Anesthesiologist since April 1997 with a subspecialty certification in Critical Care Medicine since September 1997.[6] Respondent does not hold a subspecialty certification in pain medicine, or in hospice and palliative medicine, nor does Respondent participate in the American Board of Anesthesiology's Maintenance of Certification in Anesthesiology (MOCA®) program.[7]

26. In 2003, Respondent was involved in a serious car accident during which she suffered a traumatic brain injury, vertebral artery dissection,[8] dysautonomia,[9] and postural orthostatic tachycardia syndrome ("POTS").[10] After the car accident, Respondent was bedridden for twelve (12) years and under the care of a psychiatrist until she started walking again. Respondent did not practice medicine during this time.

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[6] Per the American Board of Anesthesiology Certification Details website, certificates issued prior to January 1, 2000 are non-time limited and do not have an expiration date.

[7] The main components of the MOCA® Program are: maintaining active and unrestricted licensure; completing 250 credits of Category 1 CME activities (including 20 patient safety); answering 120 MOCA Minute questions every year and meeting the performance standard; and collecting 50 points of Quality Improvement (QI) activities during a 10-year MOCA cycle (25 points in years 1 to 5 and 25 points in years 6 to 10). The American Board of Anesthesiology encourages all diplomates to participate in MOCA, however, participation is voluntary for diplomates certified prior to 2000.

[8] Vertebral artery dissection occurs when a tear forms in one or more layers of the vertebral artery, the vessel that delivers oxygen-rich blood to the brain and spine. It is potentially disabling and may lead to ischemic stroke.

[9] Dysautonomia is a disorder of the autonomic nervous system that causes disturbances in all or some autonomic functions, including but not limited to, involuntary body functions such as heart rate, blood pressure, breathing, digestion, body and skin temperature, hormonal function, bladder function, and many other functions.

[10] Postural Orthostatic Tachycardia Syndrome, or POTS, is a condition that causes a number of symptoms when a person transitions from lying down to standing up, such as a fast heart rate, dizziness, and fatigue.

27. .Respondent returned to practicing medicine in March 2018. On or about July 1, 2018, Respondent took over a practice in Malibu, California and began practicing solo pain management. Respondent maintained an online patient portal personally monitored by her to facilitate patient communication with her. Respondent did not share call with any other physician and did not have active, provisional, or proctored hospital privileges at any facility.

28. In November 2018, Respondent relocated her practice to Woodland Hills due to the Woolsey Fire in Malibu, California.

29. On June 6, 2022, Respondent submitted to an interview by Board investigators in relation to her care and treatment of Patient A and Patient B.

PATIENT A

30. Patient A[11] was a then 54-year-old female resident of Ohio. As of 2019, Patient A had undergone three cervical spine surgeries after which she began experiencing increased pain, the cause of which her doctors could not explain. In approximately January 2019, Patient A learned of Respondent's pain management practice through a Facebook group and contacted Respondent's office to inquire about making an appointment for a consultation.

31. Before any appointment was made, Respondent's office manager instructed Patient A to send her most recent MRI imaging studies to Respondent for review. Patient A sent the imaging studies to Respondent via priority mail, guaranteed delivery by January 23, 2019. On January 29, 2019, Respondent's office manager confirmed receipt of the imaging studies.

32. On or about February 4, 2019, Patient A scheduled an appointment with Respondent to take place on February 18, 2019. In addition to an examination, the appointment was to include a review by Respondent of Patient A's MRI imaging and prior records. Patient A was instructed to obtain and provide a copy of her medical records going back at least one year for the appointment.

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[11] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred herein.

33. On or about February 5 or 6, 2019, Respondent's office manager called Patient A to arrange for payment for the appointment in the amount of $800.00. Thereafter, Respondent's office sent Patient A the new patient intake packet for completion.

34. On February 10, 2019, Patient A executed an Appointments and Payment Agreement for Patient A's appointment with Respondent. The terms of the Appointments and Payment Agreement indicated that the cost of a consultation with Respondent was $800.00, and included, among other things, an MRI review with opinion.

35. On February 12, 2019, Patient A advised Respondent's office manager that the new patient intake packet was completed, scanned, and ready for transmittal. Patient A also advised she had pharmacy documents and a copy of her medical records, consisting of 1,460 pages.

36. On February 18, 2019, Patient A presented to Respondent's office accompanied by her adult son and copies of her medical records as requested by Respondent. Respondent and Patient A discussed Patient A's medical history and symptoms. Respondent performed a brief examination and took photographs of Patient A's back and feet, but Respondent did not review the MRI studies provided by Patient A. Based on Patient A's symptoms, history, and physical examination, Respondent diagnosed Patient A with Ehlers-Danlos syndrome[12] and adhesive arachnoiditis.[13]

37. After making the diagnosis, Respondent took a vial of ketamine out of a drawer, put it in a brown plastic prescription bottle, and handwrote two labels to adhere to the prescription bottle. On one label, Respondent handwrote her own name, address, and phone number. On the other label, Respondent handwrote Patient A's name, date of birth, and directions to "inject 0.025 (1/4 of 0.1 ml) to 0.1 ml every 2 to 4 hours for severe pain." After placing the labels on the prescription bottle, Respondent dispensed it to Patient A, the ultimate user, along with a pack of

[12] Ehlers-Danlos syndrome is a group of inherited disorders that affects connective tissue, primarily the skin, joints, and blood vessel walls. Symptoms include overly flexible joints, elastic, fragile skin, and in some cases, dilatation and rupture of major blood vessels.

[13] Adhesive arachnoiditis is a rare pain disorder caused by inflammation of the arachnoid, one of the membranes that surrounds and protects the nerves of the spinal cord. It can cause severe pain and neurological symptoms. As the condition progresses, it can lead to the formation of scar tissue and cause the spinal nerves to adhere and malfunction.

syringes, directing her to follow up with Respondent's office manager for instructions on how to inject the ketamine. During her interview with the board investigators, Respondent stated that she had trained her office manager on how to teach patients to self-inject medication, and also stated her office manager was a medical assistant.

38. Prior to dispensing the ketamine to Patient A, Respondent did not offer to give a written prescription to Patient A so that Patient A could elect to have the prescription filled by Respondent or by any pharmacy.

39. Prior to dispensing the ketamine to Patient A, Respondent did not provide Patient A with written disclosure that Patient A had a choice between obtaining the prescription from Respondent or at a pharmacy of Patient A's choice.

40. Respondent did not consult Patient A's Patient Activity Report or information from the Patient Activity Report obtained from the CURES database to review Patient A's controlled substance history for the past 12 months before prescribing and dispensing ketamine, a Schedule III controlled substance, to Patient A for the first time.

41. After prescribing, dispensing, and releasing ketamine to Patient A, Respondent did not report to the CURES database the information required to be reported pursuant to Health and Safety Code section 11165, including but not limited to, the name, address, date of birth, gender, and, if available, the telephone number, of the ultimate user.

42. Patient A's records from Respondent's office practice do not reflect the fact that Respondent prescribed and dispensed ketamine to Patient A on February 18, 2019.

43. Patient A did not have experience self-injecting medication and so informed Respondent when Respondent prescribed, dispensed, and released ketamine to her. Nonetheless, Respondent did not provide any self-injection education to Patient A.

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44. After leaving Respondent's office, Patient A sent Respondent a message via the patient portal reminding Respondent that Patient A could not administer the ketamine until she received instructions. Patient A texted a similar message to Respondent's office manager. Respondent did not respond to Patient A's message. Respondent's office manager[14] responded and texted a graphic image to Patient A depicting where on the body subcutaneous injections could be administered and offering to FaceTime with Patient A to show her how to self-inject.

45. On February 19, 2019, Patient A communicated with Respondent's office manager to ask about dosing and to report Patient A's reaction to the ketamine after administration. In response to Patient A stating she was afraid of having a reaction and inquiring whether intolerance to ketamine showed at the dose she had self-administered, Respondent's office manager replied by saying "hard to say because everyone is different" and "she gave you a range to work with. So next dose you can go up if feel you need to."

46. Respondent's office manager spoke with Board investigators via telephone. During the telephonic conference, Respondent's office manager stated it was common practice for her to instruct patients on how to self-inject medications. Respondent's office manager further stated that she, the office manager, had to make sure the patients were taking the proper dosages, and that she, the office manager, would have to stay on FaceTime with patients to make sure the patients did not have any adverse reactions to the medications.

47. Patient A self-injected ketamine on February 19 and 20, 2019, but thereafter stopped due to fears of continued use without medical supervision.

48. Patient A was expecting a follow-up appointment or phone call with Respondent to discuss the MRI findings that supported the diagnosis of adhesive arachnoiditis, as per the Appointments and Payment Agreement signed on February 10, 2019, but no such follow-up occurred.

49. During her interview with Board investigators, Respondent acknowledged discussing ketamine with Patient A on February 18, 2019, but stated Patient A never provided Respondent

[14] Respondent's office manager was referred to as a "medical assistant" but did not have a certificate from any training institution or instructor pursuant to Business and Professions Code section 2069(b)(1).

with copies of Patient A's imaging studies, medical records, or the pharmacy information where Respondent could call in a prescription, and said for that reason, Respondent had not prescribed controlled substances to Patient A.

50. During her interview with Board investigators, Respondent denied dispensing ketamine to Patient A or any other patient, except for "maybe once," but stated it was a different patient.

51. During her interview with Board investigators, Respondent denied purchasing ketamine from a pharmacy and having it delivered to her office. Respondent stated the small amount of ketamine and hydromorphone Respondent had in her office had been transferred to her by Dr. T,[15] the physician from whom she had taken over the practice, amounting to "like one bottle of hydromorphone and maybe two small bottles of ketamine."

52. Respondent denies performing ketamine infusions in the office, stating she used the ketamine left over from Dr. T only for the "extremely rare" occasions when Respondent needed to administer a ketamine test dose in the office, and stating further that once those two small bottles of ketamine ran out, Respondent stopped prescribing ketamine.

53. Respondent stated a record of the transfer of the ketamine and hydromorphone from Dr. T to her had existed but was lost during the Woolsey fire in November 2018.

54. Respondent produced Patient A's medical chart in December 2020. The handwritten record for the visit of February 18, 2019 is dated February 18, 2020. Respondent states that is a mistake.

PATIENT B

55. Patient B was a then 20-year-old female resident of Arizona suffering from chronic, intractable head pain. Prior to presenting to Respondent, Patient B had most recently been treated for the head pain by a healthcare provider in Arizona, but she had also been a patient of Dr. T before he transferred the practice to Respondent. Patient B reported to Respondent that Dr. T was the local doctor referring her to Respondent.

[15] For purposes of clarity, the physician whose practice Respondent took over will be referred to as Dr. T.

56. On January 1, 2020, in anticipation of her appointment with Respondent, Patient B completed Respondent's intake packet, including consents and treatment agreements. Patient B presented to Respondent's office on January 7, 2020, and on or before that date, Patient B provided Respondent with medical records from her most recent healthcare provider in Arizona.

57. The records provided by Patient B to Respondent included a note dated October 24, 2019. The records showed that the provider had been prescribing Patient B hydromorphone 50-75 mg subcutaneously every 4 to 6 hours, and Patient B reported taking 5 mL per day of the hydromorphone. Patient B reported having gone through a sudden detox in December 2019, after her healthcare provider's license was suspended and was no longer able to continue prescribing to Patient B.

58. In the progress note for the visit of January 7, 2020, Respondent noted that the reason for the appointment was *intractable low back pain.* Patient B did not complain of back pain. Patient B's chief complaint was related to chronic head pain thought to be attributable to wisdom tooth extraction several years prior.

59. Patient B reported having prior diagnoses that included: hemicrania continua,[16] intractable pain,[17] coccidioidomycosis meningitis,[18] neck muscle spasms, and retrolisthesis[19] of vertebrae. Based on the visit of January 7, 2020, Respondent gave Patient B new diagnoses,

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[16] Hemicrania continua is a chronic and persistent form of headache marked by continuous pain that varies in severity, occurs on the same side of the face and head, and is superimposed with additional debilitating symptoms.

[17] Intractable pain refers to pain that is difficult to treat or manage with standard medical care.

[18] Coccidioidomycosis meningitis is a form of disseminated fungal infection that establishes a tissue-destructive lesion in the meninges. Coccidioidomycosis is also known as Valley Fever.

[19] Retrolisthesis is a posterior or backward slippage of a vertebral body over the one beneath. It is the opposite of spondylolisthesis, which is an anterior or forward slip. Of the two, retrolisthesis is not common.

including, but not limited to, Ehlers-Danlos syndrome (EDS), cerebrospinal fluid (CSF) leak,[20] and central pain syndrome.[21]

60. Patient B had no history of damage or dysfunction involving the brain, brainstem, or spinal cord (i.e., stroke, multiple sclerosis, tumor, or spinal cord injury). Respondent did not perform or order any laboratory or imaging studies of Patient B.

61. During Respondent's interview and in a cover letter that accompanied Patient B's medical records when provided to the board, Respondent stated she did not document the visit with Patient B until February 8 to 10, 2022, more than two years after seeing Patient B.

62. Respondent prescribed Patient B a number of medications, including fentanyl patches 72 hours at 25 micrograms per hour (1 patch every 72 hours), with hydromorphone (50 milligrams per milliliter) injectable, at 0.20 to 0.25 milliliters (10 to 12.5 milligrams) subcutaneously, twice daily, as needed. These are large doses of controlled substances. Respondent did not keep a copy of the prescription order in the medical record and did not timely document in the record whether the prescriptions for these Schedule II drugs were written, telephonic, or electronic, or whether the medication was dispensed to Patient B at the office.

63. During the interview with Board investigators, Respondent denied dispensing medications at her practice.

64. In the late-entered note of February 2022, Respondent documented dispensing 20 mL of hydromorphone to Patient B at the office visit of January 7, 2020, and prescribing other medication, including but not limited to, fentanyl patch 25 micrograms per hour, 1 patch every 3 days, on January 14, 2020.

65. Respondent did not consult Patient B's Patient Activity Report or information from the Patient Activity Report obtained from the CURES database to review Patient B's controlled

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[20] Central spinal fluid surrounds the brain and spinal cord and provides a cushion to protect them from injury. A leak occurs when there is a hole or tear in the outermost layer of these membranes (dura matter), which allows some of the fluid to escape.

[21] Central pain syndrome is a neurological condition caused by damage to or dysfunction of the central nervous system (CNS, which includes the brain, brainstem, and spinal cord). This syndrome can be caused by stroke, multiple sclerosis, tumors, epilepsy, brain or spinal cord trauma, or Parkinson's disease.

substance history for the past 12 months before prescribing and dispensing hydromorphone, a Schedule II controlled substance, to Patient B for the first time.

66. Respondent did not consult Patient B's Patient Activity Report or information from the Patient Activity Report obtained from the CURES database to review Patient B's controlled substance history for the past 12 months before prescribing fentanyl patches, a Schedule II controlled substance, to Patient B for the first time.

67. After prescribing, dispensing, and releasing hydromorphone to Patient B, Respondent did not report to the CURES database the information required to be reported pursuant to Health and Safety Code section 11165, including but not limited to, the name, address, date of birth, gender, and, if available, the telephone number, of the ultimate user.

68. After prescribing fentanyl patches to Patient B, Respondent did not report to the CURES database the information required to be reported pursuant to Health and Safety Code section 11165, including but not limited to, the name, address, date of birth, gender, and, if available, the telephone number, of the ultimate user.

69. On January 17, 2020, Patient B sent a message to Respondent via the online patient portal as follows: "I will be changing my fentanyl patch in a couple of hours. I haven't felt any different since I put it on 3 days ago. I am wondering if I need to be on a higher dose. What do you think?" Per the record, the action taken on January 29, 2020, in response to this patient portal message was: "Pt (sic.) notified by letter." There is no documentation regarding what Patient B was notified about, nor is a copy of the letter included in the record.

70. At the interview with the Board investigators, Respondent stated the patient portal message of January 17, 2020, triggered a "pill count." The "pill count" consisted of Respondent asking her office to telephone Patient B to request she take a picture of her bottle of hydromorphone with Patient B indicating with her thumb where the level of the medication was in the vial. Respondent stated that when she received the photograph requested, Respondent noted that over one-quarter of the medication was gone, which caused Respondent to send a letter to Patient B, by regular mail and certified mail, "telling her that she self-terminated from the clinic." A copy of the termination letter is not contained in Patient B's medical records.

. 71. . The medical records produced by Respondent for Patient B include several photographs. The name indicated on the photographs in Patient B's chart reflect a different patient's name.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dishonest or Corrupt Acts)

72. Respondent Margaret Aranda, M.D. is subject to disciplinary action under section 2234, subdivisions (a) and (e), section 2261, section 2262, and section 2266 of the Code, in that Respondent engaged in acts involving dishonesty or corruption substantially related to the qualifications, function, or duties of a physician and surgeon, as follows:

PATIENT A:

73. The facts and allegations set forth in paragraphs 25 through 54 are incorporated herein by reference as if fully set forth.

Dishonesty Regarding Source and Possession of Ketamine

74. Respondent was dishonest in her denial of purchasing ketamine from a pharmacy. Respondent falsely claimed that she only had two small bottles of ketamine at her practice, and that once those ran out, she stopped prescribing ketamine. Purchase records from a pharmacy show that Respondent purchased thirty-nine (39) vials of ketamine from December 2018 through February 2020.

75. Respondent was dishonest about the source of the two vials of ketamine she reported as transferred to Respondent by Dr. T. Dr. T denied transferring any medications to Respondent, and Respondent's office manager confirmed that no medication had been transferred to Respondent when Respondent took over the practice.

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76. Respondent was dishonest about the existence of a record of the alleged transfer of medications. As above, Respondent falsely claimed there was a transfer of medication and a record of said transfer of medications. Respondent then falsely claimed the record of the transfer was lost in the Woolsey fire due to theft. The investigation revealed there is no evidence, report, or record of fire damage to the building that housed Respondent's practice as of November 2018; no evidence, report, or record of theft or vandalism to any storage unit in that building; and further, there is no evidence that Respondent even maintained a storage unit in that building.

Dishonesty Regarding Respondent's Prescribing and Dispensing Practices

77. Respondent was dishonest in stating that she stopped prescribing ketamine once the two small bottles of ketamine ran out. Respondent's CURES Prescription History Report shows hundreds of ketamine prescriptions from July 2018 through September 2022.

78. Respondent was dishonest in stating that it was not her practice to dispense ketamine to patients. There is evidence that Respondent dispensed ketamine to patients out of her office, selling it to patients at a price higher than Respondent's cost.

Dishonesty Regarding Prescribing and/or Dispensing of Ketamine to Patient A

79. Respondent was dishonest in her denial of having prescribed and dispensed ketamine to Patient A on February 18, 2019, as evidenced by photographic and documentary evidence of the ketamine vial and syringes dispensed to Patient A by Respondent.

Knowingly Making or Signing a Document Which Falsely Represents the Existence or Nonexistence of a State of Facts

80. Respondent produced Patient A's medical chart in December 2020. The handwritten record for the visit of February 18, 2019 is dated February 18, 2020. During her interview with Board investigators, Respondent claimed that was a "typo."

81. Respondent did not document in Patient A's chart that Respondent prescribed and dispensed ketamine to Patient A. Instead, Responding knowingly made and signed a document, to wit, the handwritten in-office progress note, which falsely represents the state of facts.

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82. .Respondent falsely documented in Patient A's chart that ketamine therapy was being considered as a *potential* therapy and did not document the fact that ketamine was prescribed and dispensed at the visit of February 18, 2019.

83. Respondent falsely documented in Patient A's chart that there were two main items that Patient A understood she had to provide before Respondent would prescribe to Patient A. First, Patient A was to provide the name of a pharmacy or pharmacist that would agree to fill the prescription. Second, Patient A was to provide Respondent with a copy of her primary care provider's records, which Respondent claimed Patient A had not provided and/or brought with her to the appointment. These statements in the medical record knowingly and falsely represent the state of facts as Patient A provided her prior medical records to Respondent, and Respondent in fact prescribed and dispensed ketamine to Patient A on February 18, 2019.

Altering or Modifying or Creating the Medical Record with Fraudulent Intent

84. Respondent altered and/or modified and/or created the handwritten record of the February 18, 2019 visit with fraudulent intent to conceal the fact that Respondent prescribed and dispensed ketamine to Patient A in the office and failed to report it to CURES.

Failure to Maintain Adequate and Accurate Records

85. Respondent failed to maintain adequate and accurate records relating to the provision of services to Patient A in that Respondent failed to document in Patient A's record the fact of having prescribed and dispensed ketamine to Patient A, including the dose and quantity or a record of the prescription order.

PATIENT B:

86. The facts and allegations set forth in paragraphs 25 through 29, and paragraphs 55 through 71, are incorporated herein by reference as if fully set forth.

Dishonesty Regarding Respondent's Prescribing and Dispensing Practices

87. Respondent was dishonest during her interview with the Board investigators in stating that she did not dispense medications at her practice. In Respondent's late-entered note signed February 10, 2022, Respondent states she dispensed hydromorphone, a Schedule II controlled substance, to Patient B at the office visit.

SECOND CAUSE FOR DISCIPLINE

(Failure to Comply with Statutes and Regulations for Prescribing and Dispensing Controlled Substances)

88. Respondent Margaret Aranda, M.D. is subject to disciplinary action under section 2234, subdivisions (a), section 2238, section 2241.5, subdivisions (c)(5) and (c)(7), section 2266, and section 4170 of the Code, and section 11165, subdivision (d), section 11165.1, subdivision (a)(1)(B)(iv), section 11165.4, subdivisions (a)(1)(B)(2) and (d)(1), section 11171, and section 11190, subdivision (c) of the Health and Safety Code, in that Respondent failed to comply with statutes and regulations for prescribing and dispensing controlled substances with respect to Patient A and Patient B, as follows:

89. The facts and allegations set forth in paragraphs 25 through 71 are incorporated herein by reference as if fully set forth.

90. The facts and allegations set forth in the First Cause for Discipline are incorporated herein by reference as if fully set forth.

91. Each of the alleged acts of dishonesty or corruption set forth in the First Cause for Discipline, above, are also failures to comply with statutes and regulations for prescribing and dispensing controlled substances.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

92. Respondent Margaret Aranda, M.D. is subject to disciplinary action under section 2234, subdivisions (a) and (b) of the Code, in that Respondent was grossly negligent in her care and treatment of Patient A and Patient B. The circumstances are as follows:

93. The facts and allegations set forth in paragraphs 25 through 71 are incorporated herein by reference as if fully set forth.

94. The facts and allegations set forth in the First Cause for Discipline are incorporated herein by reference as if fully set forth.

95. Each of the alleged acts of dishonesty or corruption set forth in the First Cause for Discipline, above, are also grossly negligent acts.

96. The facts and allegations set forth in the Second Cause for Discipline are incorporated herein by reference as if fully set forth.

97. Each of the alleged acts of failure to comply with statutes and regulations for prescribing and dispensing controlled substances set forth in the Second Cause for Discipline, above, are also grossly negligent acts.

PATIENT A

98. Respondent diagnosed Patient A with adhesive arachnoiditis. The standard of care for diagnosing arachnoiditis includes a history, relevant symptomatology, physical examination, and MRI findings. MRI is the most sensitive and specific test for arachnoiditis. A contrast MRI of the lumbar-sacral spinal canal is required for a confirmatory diagnosis. Respondent neither reviewed the MRI imaging studies provided by Respondent nor ordered an MRI study performed on Patient A prior to making the diagnosis. Respondent's failure to complete the full assessment necessary for a definitive diagnosis of adhesive arachnoiditis, which diagnosis was used as part of a basis for pain management and palliative care, is an extreme departure from the standard of care.

99. Respondent diagnosed Patient A with Ehlers-Danlos syndrome (EDS). The diagnosis of EDS is made clinically, based upon the family history and physical examination. Respondent failed to make any notation of a family history of EDS, failed to test for, or note findings of, any of the major or minor criteria for the diagnosis of EDS, and failed to make a referral for genetic testing. The Beighton hypermobility scale, a screening tool for EDS which is the only indication of an EDS screening in Patient A's chart, does not support the diagnosis of EDS because Patient A's score on that scale was a 1 out of 9, whereas a positive Beighton score for adults is 5 out of 9. Respondent's failure to assess Patient A for the standard diagnostic criteria for EDS, which diagnosis was used as part of a basis for pain management and palliative care, is an extreme departure from the standard of care.

100. Patient A did not have experience self-injecting medication. For such patients, the standard of care requires that physicians, either themselves or through a qualified healthcare provider, provide proper self-injection education to the patient. This should include, but is not

limited to, education regarding appropriate storage of medication, injection site selection, and rotating injection sites (if applicable), instruction regarding how to prepare and draw up the medication for injection, correct administration technique, techniques for proper infection control, and safe disposal of sharps.

101. In addition to failing to document in the chart the prescribing and dispensing of ketamine to Patient A, Respondent failed to provide any patient education on safe and proper self-injection. Respondent's failure to provide adequate information and/or education to Patient A regarding self-administration and dosing of ketamine, a controlled substance, is an extreme departure from the standard of care.

102. Respondent's practice was to have Respondent's office manager, a medical assistant, observe and/or monitor and/or assess patients after administration of medications to make sure the patients did not have any adverse reactions to the medications. Medical assistants are unlicensed, and may only perform basic administrative, clerical and technical supportive services as permitted by law. An unlicensed person may not diagnose or treat or perform any task that is invasive or requires assessment. Respondent's practice of having Respondent's office manager observe and/or monitor and/or assess patients for adverse reactions after administration of medication is an extreme departure from the standard of care.

PATIENT B

103. The standard of care requires physicians to maintain adequate and accurate medical records. When seeing a patient for the first time, this includes a formal history and physical examination, current medications, social and family histories, known drug allergies, all current medications and doses, relevant lab and imaging studies, a review of prior records, if available, and a relevant assessment and plan for the conditions being treated. If medications are prescribed, it would also include the names, doses, frequencies, and relevant instructions for those medications.

104. Respondent failed to timely document a history and physical until February 8 through 10, 2022, over two years later. As the office visit of January 7, 2020, involved a complicated patient and the treatment of chronic pain with Schedule II controlled substances, in addition to a

number of other medications, as part of a treatment program for intractable pain and palliative care, the failure to timely document the history and physical was an extreme departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

105. Respondent Margaret Aranda, M.D. is subject to disciplinary action under section 2234, subdivisions (a) and (c) of the Code, in that Respondent provided negligent care and treatment to Patient A and Patient B. The circumstances are as follows:

106. The facts and allegations set forth in paragraphs 25 through 71 are incorporated herein by reference as if fully set forth.

107. The facts and allegations set forth in the Third Cause for Discipline are incorporated herein by reference as if fully set forth.

108. Each of the alleged acts of gross negligence set forth in the Third Cause for Discipline, above, are also negligent acts.

PATIENT A

109. Patient A requested and was charged for a new patient visit to include an MRI consultation. Respondent acknowledged that the $800.00 fee was for a consultation including review of the MRI. Respondent's failure to fulfill her duty as committed through contract and payment to read Patient A's MRI, and Respondent's subsequent failure to refund Patient A for the services not provided, was a simple departure from the standard of care.

PATIENT B

110. The standard of care requires physicians to maintain adequate and accurate records, including the correct patient name and identifying information on each document entered into the medical record. In addition, patient information and records should not be placed into the medical records of a different patient. The medical records submitted by Respondent for Patient B include several photographs. The name indicated on the photographs in Patient B's medical record reflect a different patient's name. Placing incorrect and conflicting patient information in the medical record is a simple departure from the standard of care.

111. The standard of care for maintaining adequate and accurate records also requires a physician to be deliberate and accurate in documenting all components of the history and physical, including accurate documentation for the reason for the patient's visit (the chief complaint). In the progress note for the visit of January 7, 2020, Respondent notes that the reason for the appointment was intractable low back pain. Patient B did not complain of back pain. Patient B's chief complaint was related to chronic head pain thought to be attributable to wisdom tooth extraction several years prior, resulting in hemicrania continua. Respondent's failure to adequately and accurately document Patient B's chief complaint is a simple departure from the standard of care.

112. Respondent diagnosed Patient B with Ehlers-Danlos syndrome (EDS). The diagnosis of EDS is made clinically, based upon the family history and physical examination. There are multiple forms of EDS, but joint hypermobility or laxity is the hallmark of most types of EDS. In addition, pes planus (flat feet) is common in all forms, and pectus excavatum (sunken breastbone) and a high arched palate can also be present in all of the forms of EDS. Generally speaking, diagnosis in one of its forms should be suspected when a patient presents with some combination of features seen in one or several of the types of EDS, including joint hypermobility, multiple joint dislocations, translucent skin, skin hyperextensibility, poor wound healing, easy bruising, unusual scars, and a family history of EDS. A patient suspected of having EDS based upon their clinical presentation and family history should also be referred for consultation with an expert in clinical genetics or the care of patients with EDS, for confirmation of the diagnosis and the institution of multidisciplinary management and follow-up care.

113. With respect to Patient B, Respondent's assessments for EDS revealed all negative responses on the EDS screening form. Likewise, the Beighton hypermobility scale does not support the diagnosis of EDS because Patient B's score on that scale was a 2 out of 9, whereas a positive Beighton score for adults is 5 out of 9. Patient B is not noted by Respondent to have a family history of EDS, and Respondent did not note any historical information or physical examination findings required for the diagnosis of EDS, except for flat feet, which is a very

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common foot deformity and not pathognomonic[22] for EDS. The necessary diagnostic criteria for EDS were not met in Patient B, nor did Respondent refer Patient B for genetic testing. Respondent's diagnosis of EDS in Patient B without meeting the standard of care for diagnosing EDS, and with multiple lines of evidence suggesting Patient B did not satisfy criteria for EDS, was a simple departure from the standard of care.

FIFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting in the Unlicensed Practice of Medicine)

114. Respondent Margaret Aranda, M.D. is subject to disciplinary action under section 2234, subdivisions (a), and section 2264 of the Code, in that Respondent aided and abetted an unlicensed person to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice, with respect to Patient A. The circumstances are as follows:

115. The facts and allegations set forth in paragraphs 25 through 54 and paragraph 102, are incorporated herein by reference as if fully set forth.

116. Respondent's practice of having Respondent's office manager, an unlicensed person, teach patients how to self-inject medications constituted aiding and abetting an unlicensed person to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice.

117. Respondent's practice of having Respondent's office manager, an unlicensed person, observe and/or monitor and/or assess patients for adverse reactions after administration of medication constituted aiding and abetting an unlicensed person to engage in the unlicensed practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice.

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[22] Pathognomonic means specifically characteristic or indicative of a particular disease or condition.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 73982, issued to Margaret Aranda, M.D.;

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

3. Ordering Margaret Aranda, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: NOV 04 2022

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

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