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10 **BEFORE THE**  
11 **MEDICAL BOARD OF CALIFORNIA**  
12 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

13 In the Matter of the Second Amended  
14 Accusation Against:

Case No. 800-2017-035630

15 **TARA ALAINA ZANDVLIET, M.D.,**  
16 **2991 Kalmia St.**  
**San Diego, CA 92104**

**SECOND AMENDED ACCUSATION**

17 **Physician's and Surgeon's Certificate**  
18 **No. A 71646,**

Respondent.

19  
20 **PARTIES**

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

24 2. On or about May 11, 2000, the Board issued Physician's and Surgeon's Certificate  
25 No. A 71646 to Tara Alaina Zandvliet, M.D. (Respondent). The Physician's and Surgeon's  
26 Certificate was in full force and effect at all times relevant to the charges brought herein and will  
27 expire on July 31, 2023, unless renewed.

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## JURISDICTION

3. This Second Amended Accusation, which supersedes the First Accusation filed on November 30, 2020, in the above-entitled matter, is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

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.

...

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

1 (2) When the standard of care requires a change in the diagnosis, act, or  
2 omission that constitutes the negligent act described in paragraph (1), including, but  
3 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.

4 (d) Incompetence.

5 ...

6 6. Section 2266 of the Code states:

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

9 7. Section 2241.5 of the Code states:

10 (a) A physician and surgeon may prescribe for, or dispense or administer to, a  
11 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  
12 pain, including, but not limited to, intractable pain.

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

15 (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  
16 following:

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

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

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

21 ...

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

24 (d) A physician and surgeon shall exercise reasonable care in determining  
25 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  
26 consultation with, or referral to, a more qualified specialist.

27 ...

28 ////

1           8.     Section 4021 of the Code states:

2                 “Controlled substance” means any substance listed in Chapter 2 (commencing  
3                 with Section 11053) of Division 10 of the Health and Safety Code.

4           9.     Section 4022 of the Code states:

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

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

9                 ...

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

12           10.    Unprofessional conduct under Business and Professions Code section 2234 is conduct  
13           that breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to  
14           a member in good standing of the medical profession, and which demonstrates an unfitness to  
15           practice medicine.<sup>1</sup>

#### 16                                 **OTHER RELEVANT STATUTORY PROVISIONS**

17           11.    Section 120335 of the Health and Safety Code states:

18                 (a) As used in this chapter, ‘governing authority’ means the governing board of  
19                 each school district or the authority of each other private or public institution  
20                 responsible for the operation and control of the institution or the principal or  
21                 administrator of each school or institution.

22                 (b) The governing authority shall not unconditionally admit any person as a  
23                 pupil of any private or public elementary or secondary school, child care center, day  
24                 nursery, nursery school, family day care home, or development center, unless, prior to  
25                 his or her first admission to that institution, he or she has been fully immunized. The  
26                 following are the diseases for which immunizations shall be documented:

- 27                         (1) Diphtheria.  
28                         (2) Haemophilus influenzae type b.  
                          (3) Measles.  
                          (4) Mumps.  
                          (5) Pertussis (whooping cough).  
                          (6) Poliomyelitis.  
                          (7) Rubella.  
                          (8) Tetanus.  
                          (9) Hepatitis B.  
                          (10) Varicella (chickenpox).

<sup>1</sup> *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

1 (11) Any other disease deemed appropriate by the department, taking into  
2 consideration the recommendations of the Advisory Committee on  
3 Immunization Practices of the United States Department of Health and Human  
4 Services, the American Academy of Pediatrics, and the American Academy of  
5 Family Physicians.

6 (c) Notwithstanding subdivision (b), full immunization against hepatitis B shall  
7 not be a condition by which the governing authority shall admit or advance any pupil  
8 to the 7th grade level of any private or public elementary or secondary school.

9 (d) The governing authority shall not unconditionally admit or advance any  
10 pupil to the 7th grade level of any private or public elementary or secondary school  
11 unless the pupil has been fully immunized against pertussis, including all pertussis  
12 boosters appropriate for the pupil's age.

13 (e) The department may specify the immunizing agents that may be utilized and  
14 the manner in which immunizations are administered.

15 ...

16 (g)(1) A pupil who, prior to January 1, 2016, submitted a letter or affidavit on  
17 file at a private or public elementary or secondary school, child day care center, day  
18 nursery, nursery school, family day care home, or development center stating beliefs  
19 opposed to immunization shall be allowed enrollment to any private or public  
20 elementary or secondary school, child day care center, day nursery, nursery school,  
21 family day care home, or development center within the state until the pupil enrolls in  
22 the next grade span.

23 (2) For purposes of this subdivision, 'grade span' means each of the following:

24 (A) Birth to preschool.

25 (B) Kindergarten and grades 1 to 6, inclusive, including transitional  
26 kindergarten.

27 (C) Grades 7 to 12, inclusive.

28 (3) Except as provided in this subdivision, on and after July 1, 2016, the  
governing authority shall not unconditionally admit to any of those institutions  
specified in this subdivision for the first time, or admit or advance any pupil to 7th  
grade level, unless the pupil has been immunized for his or her age as required by this  
section.

...

12. Section 120370 of the Health and Safety Code states:<sup>2</sup>

(a) (1) Prior to January 1, 2021, if the parent or guardian files with the  
governing authority a written statement by a licensed physician and surgeon to the  
effect that the physical condition of the child is such, or medical circumstances

<sup>2</sup> Effective January 1, 2016, through December 31, 2019, Health and Safety Code section 120370, subdivision (a), stated: "If the parent or guardian files with the governing authority a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician does not recommend immunization, that child shall be exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician's statement."

1 relating to the child are such, that immunization is not considered safe, indicating the  
2 specific nature and probable duration of the medical condition or circumstances,  
3 including, but not limited to, family medical history, for which the physician and  
4 surgeon does not recommend immunization, that child shall be exempt from the  
requirements of this chapter, except for Section 120380, and exempt from Sections  
120400, 120405, 120410, and 120415 to the extent indicated by the physician and  
surgeon's statement.

5 (2) Commencing January 1, 2020, a child who has a medical exemption issued  
6 before January 1, 2020, shall be allowed continued enrollment to any public or  
private elementary or secondary school, child care center, day nursery, nursery  
school, family day care home, or developmental center within the state until the child  
enrolls in the next grade span.

7 For purposes of this subdivision, "grade span" means each of the following:

8 (A) Birth to preschool, inclusive.

9 (B) Kindergarten and grades 1 to 6, inclusive, including transitional  
kindergarten.

10 (C) Grades 7 to 12, inclusive.

11 ...

## 12 DEFINITIONS

13 13. Controlled Substance Utilization Review and Evaluation System (CURES) is a  
14 database of Schedule II, III and IV controlled substance prescriptions dispensed in California. It  
15 is compiled by the California Department of Justice, Bureau of Criminal Identification and  
Investigative Services as part of its Prescription Drug Monitoring Program.

16 14. Oxycontin is the brand name of a time-release formula of oxycodone, a Schedule II  
17 controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a  
18 dangerous drug pursuant to Business and Professions Code section 4022.

19 15. Oxymorphone is a Schedule II controlled substance pursuant to Health and Safety  
20 Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions  
21 Code section 4022.

22 16. Dilaudid is a brand name for hydromorphone, a Schedule II controlled substance  
23 pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug  
24 pursuant to Business and Professions Code section 4022.

25 17. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code  
26 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code  
27 section 4022.

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1        18. Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II  
2 controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a  
3 dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine  
4 salt used for attention-deficit hyperactivity disorder and narcolepsy.

5        19. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code  
6 section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code  
7 section 4022.

8        20. Hydrocodone Bitartrate is a Schedule II controlled substance pursuant to Health and  
9 Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and  
10 Professions Code section 4022.

11       21. Xanax is a brand name for alprazolam (a benzodiazepine), a Schedule IV controlled  
12 substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous  
13 drug pursuant to Business and Professions Code section 4022.

14       22. Tramadol, an opioid analgesic, is a Schedule IV drug under the Uniform Controlled  
15 Substances Act and a dangerous drug pursuant to Business and Professions Code section 4022.

16       23. Soma, a muscle relaxant, is a brand name for carisoprodol, a Schedule IV drug under  
17 the Uniform Controlled Substances Act.

18       24. Narcan is a brand name for naloxone, a medication used to block the effects of  
19 opioids. It is commonly used to counter decreased breathing in opioid overdose, and is a  
20 dangerous drug pursuant to Business and Professions Code section 4022.

21       25. Suboxone contains buprenorphine and naloxone. It is a Schedule V controlled  
22 substance under Health & Safety Code Section 11058(d), and a dangerous drug pursuant to  
23 Business and Professions Code section 4022. Suboxone is FDA-approved for treatment of opioid  
24 addiction.

25       26. Gabapentin is most commonly prescribed to relieve nerve pain, and is a dangerous  
26 drug pursuant to Business and Professions Code section 4022.

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1        27. Selective serotonin re-uptake inhibitors or serotonin-specific reuptake inhibitors  
2 (SSRIs) are a class of compounds typically used as antidepressants in the treatment of depression  
3 anxiety disorders, and some personality disorders.

4        28. Lexapro is a brand name for escitalopram, an SSRI antidepressant. Lexapro is used  
5 to treat depression and anxiety in adults, and is a dangerous drug pursuant to Business and  
6 Professions Code section 4022.

7        29. Cyclic antidepressants are designated as tricyclic or tetracyclic, depending on the  
8 number of rings in their chemical structure — three (tri) or four (tetra). Tricyclic antidepressants  
9 are older drugs than SSRIs, work differently, and have different side-effects.

10       30. Cyclobenzaprine is a muscle relaxant that is closely related (has a similar chemical  
11 structure) to the tricyclic antidepressants (eg, amitriptyline, imipramine). Flexeril is a brand name  
12 for cyclobenzaprine that has been discontinued in the U.S., but cyclobenzaprine remains available  
13 in other brand names. It is a dangerous drug pursuant to Business and Professions Code section  
14 4022.

15       31. Nonsteroidal anti-inflammatory drugs (NSAIDs) are drugs used to treat inflammation,  
16 mild to moderate pain, and fever. They include aspirin and ibuprofen.

17       32. The “five A’s” of chronic pain management are: analgesia, adverse side effects,  
18 functional activities, aberrancy, and patient affect.

19       33. Morphine Equivalent Dosage (MED) is a value assigned to opioids to represent their  
20 relative potencies. MED is determined by using an equivalency factor to calculate a dose of  
21 morphine that is equivalent to the ordered opioid. Daily MED (or MEDD) is the sum of the MED  
22 of all drugs in the opioid class a patient is likely to take over 24 hours, and that total is used to  
23 determine if the patient is nearing a potentially dangerous threshold. The primary side effect of  
24 opioid overdose is respiratory depression, which frequently leads to serious complications or  
25 death. Ideally, the MED of a patient’s daily opiate therapy should not exceed 80-90 mg per day.  
26 Risks of adverse effects, including drug overdose and death, increase significantly beyond this  
27 dosage.

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1       34. The DTaP vaccine protects against diphtheria, tetanus, and pertussis (whooping  
2 cough). Diphtheria is a serious infection of the throat that can block the airway and cause severe  
3 breathing problems. Pertussis is a respiratory illness with cold-like symptoms that lead to severe  
4 coughing (the “whooping” sound happens when a child breathes in deeply after a severe coughing  
5 fit). Serious complications can affect children under 1 year old, and those younger than 6 months  
6 old are especially at risk. Teens and adults with a lasting cough might have pertussis and not  
7 realize it, and could pass it to vulnerable infants.

8       35. The Tdap vaccine is a booster immunization given at age 11 that offers continued  
9 protection from diphtheria, tetanus, and pertussis for adolescents and adults.

10       36. Polio, or poliomyelitis, is a disabling and life-threatening disease caused by the  
11 poliovirus. The virus spreads from person to person and can infect a person’s spinal cord,  
12 causing paralysis. Paralysis, in turn, can lead to permanent disability and death.

13       37. Varicella, also known as chickenpox, is a very contagious disease caused by the  
14 varicella-zoster virus (VZV). It causes a blister-like rash, itching, tiredness, and fever.  
15 Chickenpox used to be very common in the United States. Serious complications of chickenpox  
16 can lead to hospitalization and death.

17       38. The MMR vaccine protects against measles, mumps and rubella. Measles is highly  
18 contagious and especially dangerous for babies and young children. It can lead to pneumonia,  
19 lifelong brain damage, deafness and death.

20       39. Hepatitis A is a serious liver disease. In rare cases, hepatitis A can cause liver failure  
21 and death. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can  
22 lead to a serious, lifelong illness.

23       40. The Hib vaccine protects against *haemophilus influenzae* type b, a disease that can  
24 cause serious illness and death in babies and children younger than 5 years old. Hib can cause  
25 severe infections of both the lining of the brain and spinal cord (meningitis) and the bloodstream.

26       41. Influenza (flu) is a contagious respiratory illness caused by influenza viruses that can  
27 cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or  
28 death, particularly in older people, young children, and people with certain health conditions.

42. Meningitis is an inflammation (swelling) of the protective membranes covering the brain and spinal cord. Bacterial meningitis can be deadly and requires immediate medical attention.

43. The HPV vaccine protects against the human papillomavirus, a very common virus that can lead to cancer.

### **FACTUAL ALLEGATIONS**

44. At all relevant times, Respondent practiced internal medicine and pediatrics at her solo practice, South Park Doctors.

#### **Patient A:**

45. Patient A<sup>3</sup> is a male minor child, born in March 2015.

46. At all times relevant to the allegations herein, Patient A received care from providers within the Kaiser Permanente healthcare system ("Kaiser").

47. Respondent saw Patient A on one occasion only, on or about March 24, 2017. On this occasion, Patient A was brought to Respondent by his parents "for consultation about vaccines and possible medical exemption" from vaccines. At the time of the visit, Patient A had received no vaccinations.

48. Patient A's family history was recorded in his chart by Respondent as follows:

- a. Second cousin – "bee sting allergy epi pen"
- b. Cousin #1 – penicillin allergy
- c. Cousin #2 – Hashimotos
- d. Great aunt – "food allergies"
- e. Great grandmother – "food allergies"
- f. Great grandfather – polyarteritis Nodosa
- g. Maternal grandmother – "RA, lupus"
- h. Mother – "[consistent with] Hashimotos, no confirmation yet"

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<sup>3</sup> For the sake of patient privacy, all patients involved in this Second Amended Accusation are designated only as "Patient A," "Patient B," etc. Their identities are known to all parties.

1 Patient A's chart contains what Respondent regards as documentation that supports the  
2 family history for the first six persons listed above (13a through 13f).

3 49. Patient A's past medical history, as recorded by Respondent in Patient A's chart,  
4 reflects "asthma, allergies – possibly food, definitely environmental."

5 50. Patient A's medical records at Kaiser reflect no known allergies. He received  
6 treatment (Zyrtec and Flovent) for environmental allergies, but testing for environmental allergies  
7 at age 2 years identified only animal (dog and cat) dander as allergy triggers. He was also  
8 hospitalized at age 2 for asthma exacerbation and discharged after one day. He visited the  
9 emergency room for diarrhea at 9 months of age.

10 51. Patient A was diagnosed with hand foot mouth disease at 12 months, and had  
11 pertussis when he was 2 ½ years old (January 4, 2018), for which both he and his entire family  
12 required antibiotic treatment. Pertussis is a vaccine preventable disease.

13 52. Respondent failed at any stage to consult Patient A's providers at Kaiser or review his  
14 Kaiser medical records.

15 53. In considering the request for a vaccine exemption, Respondent looked for "evidence  
16 that the family was of an allergic or atopic autoimmune type." Since Respondent found that  
17 Patient A has asthma and allergies, she considered him more likely to have anaphylaxis to many  
18 different things, including vaccines.

19 54. Based on "a family history of hyperimmunity and autoimmunity," Respondent's  
20 opinion was "to vaccinate slowly, [but to have] an exemption for school attendance. Choice to  
21 vaccine is up to parents." Respondent "encouraged a slow schedule."

22 55. On or about March 24, 2017, Respondent prepared the following document,  
23 providing Patient A with a permanent medical exemption from all vaccines on the Center for  
24 Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines:

25 [Patient A] DOB 3/[xx]/15 has a strong family history of Autoimmune diseases  
26 like polyarteritis Nodosa and hyperimmune conditions like anaphylaxis. Given the  
27 level of immune dysfunction in him and the family, I feel he is at a high risk of  
28 adverse reaction to vaccines. If there is an imminent medical threat in the community  
we can consider a single vaccine in a controlled medical environment, however, the  
benefits to him and the community must greatly outweigh his very real personal risk.  
This medical exemption for vaccines is permanent. It includes, but is not limited to,

1 DtaP [*sic*], Tdap, Polio, Varicella, MMR, Hep B and A, HiB, HPV, Influenza, and  
2 Meningitis, and includes all current vaccines on the CDC recommended vaccine list  
and any future vaccines placed on the list.

3 56. At an interview conducted on behalf of the Board on August 3, 2020 ("the first  
4 subject interview"), Respondent explained that she made the exemption permanent because  
5 family history "does not change for the better, it just gets worse as we diagnose more things ...;  
6 the diagnoses won't disappear." Also, the reason she made the exemption for all vaccines, both  
7 the (known) current ones and any unknown future vaccines, is because "the schools and the law  
8 require they all be listed" and the schools "wanted broad letters." In addition, since the immune  
9 system of Patient A, "based on personal history and family history is more of an atopic nature,  
10 [he] would be at a higher risk of anaphylaxis and allergic reaction to any vaccine because of the  
11 immune process; it's not vaccine specific."

12 57. Respondent's explanation and/or rationale for providing Patient A with an exemption  
13 from all vaccinations, current and future, was not consistent with, and was in direct opposition to,  
14 the recommendations of the CDC, American Academy of Pediatrics ("AAP"), and/or other  
15 guiding bodies. In fact, patients with allergies (for instance, asthma or eczema) are at greater risk  
16 from the vaccine preventable diseases (for instance, influenza in the case of patients with asthma,  
17 and varicella in the case of patients with eczema), so that vaccine is highly recommended in these  
18 patients, not contraindicated or cautioned against.

19 58. Respondent has estimated that, between the passing of California Senate Bill 277<sup>4</sup>  
20 and June 2019, she provided roughly 1,000 medical exemptions. At the first subject interview,  
21 she was unable to provide any approximation of the breakdown between permanent and  
22 temporary exemptions.

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26 <sup>4</sup> California Senate Bill 277 was a California bill that removed personal belief exemptions  
27 to vaccination requirements for entry to private or public elementary or secondary schools in  
28 California, as well as day care centers. It was passed in the California State Senate in June 2015  
and signed into law by Governor Jerry Brown on June 30, 2015.

Patient B:<sup>5</sup>

59. Patient B is an adult female born in 1988, who suffered from loin pain hematuria syndrome due to IgA nephropathy.<sup>6</sup>

60. Patient B started filling opiate prescriptions from Respondent in the second half of 2014, and had received opiates from other providers for roughly the first half of 2014:

Time Frame	Jan. 1- Jun. 23, 2014 (other providers)	Jun. 24 – Dec. 31, 2014 (Respondent)
Oxycodone	42,700 mg	90,360 mg
Hydromorphone	2,040 mg	2,880 mg
Oxycontin	2,640 mg	31,200 mg
Morphine sulfate	900 mg	
Oxymorphone		1,800 mg
Fentanyl transdermal	12 mcg/1 hr x 10	
Hydrocodone	1,220 mg	

61. At the time that Respondent assumed the sole prescribing responsibility of narcotics for Patient B (in June 2014), she had been receiving approximately 424 mg MEDD from her prior providers. Respondent escalated Patient B's narcotic prescriptions over the next 18 months so that, by December 2015, Patient B was receiving approximately 1227 mg MEDD.

62. In January 2016, Respondent was prescribing oxycodone IR, Dilaudid, and Oxycontin SR, such that Patient B's MED was approximately 1360 mg per day.

63. During the approximately three and a half year period of records reviewed, Respondent made attempts to taper down Patient B's narcotic requirements. By the end of June 2016, Patient B was down to approximately 970 mg MEDD, and by December 2016 she was down to approximately 938 mg MEDD. (For the entire 2016 year, Patient B received an MEDD in excess of 900 mg.) The lowest MEDD reached during the period reviewed for Patient B, was approximately 795 mg in December 2017.

<sup>5</sup> Records reviewed for Patient B cover the period January 4, 2016 through June 10, 2019.

<sup>6</sup> IgA nephropathy is a chronic kidney disease. It progresses over 10 to 20 years, and it can lead to end-stage renal disease.

1        64. Respondent's attempts to wean Patient B from her high doses of narcotics were often  
2 interrupted by Patient B's self-reported flares of her back and loin pains. However, her chart  
3 contains no documentation of objective evidence of the flare-ups of her kidney condition, such as  
4 hematuria,<sup>7</sup> fevers, imaging, or laboratory assessment. Respondent's clinical documentation also  
5 does not reflect any objective findings of the flare-ups and contains minimal functional and pain  
6 intensity assessments.

7        65. Respondent's chart for Patient B, generally, contains no detailed review of symptoms  
8 and no thorough physical examination findings. The progress notes make no reference to the  
9 "five A's" of chronic pain management.

10       66. In March 2018, Patient B was involved in a motor vehicle accident. By June 2018,  
11 Patient B was again receiving approximately 1017 mg MEDD, which was again weaned down to  
12 roughly 930 MEDD by the end of June 2019. This MEDD has remained at approximately the  
13 same level consistently, through at least July 1, 2020.

14       67. Patient B's chart does not show that any non-opiate drug therapies were tried  
15 (concurrently with long term opiates), such as tricyclic antidepressants, serotonergic  
16 medications, muscle relaxants, anti-seizure medications, and/or topical therapies. Cognitive  
17 behavioral therapies with mental health experts were not part of a multi-disciplinary approach by  
18 Respondent to managing Patient B's condition.

19       68. Respondent's chart for Patient B shows a rheumatology referral in March 2016 for  
20 possible rheumatoid arthritis suspected due to swollen hands, and documents that Patient B would  
21 be undergoing a nerve block procedure "on May 19." A progress note dated September 14, 2016,  
22 documents that Patient B would be having denervation and ablation surgery of the kidney for pain  
23 management, "far in the future." The chart does not document any follow-up to these anticipated  
24 consultations and/or pain management procedures.

25       69. In the progress note dated January 3, 2017, Respondent noted that Patient B was  
26 "narcotic dependent" with a high opiate tolerance. January 3, 2017, also marks the first date on  
27 which there is a documented reference to the CURES database in Patient B's chart (for the period  
28

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<sup>7</sup> The presence of blood in the urine.

1 reviewed). During Patient B's continued fortnightly visits to Respondent for the ensuing thirty  
2 (30) month period (between January 2017 and June 10, 2019), Respondent documented checking  
3 Patient B's CURES a further eleven (11) times.

4 70. Patient B's chart for the three and a half year period reviewed includes five (5)  
5 documented drug toxicology tests, with the first such test being in April 2017, followed by  
6 October 2017, February 2018, June 2018, and February 2019.

7 71. The first reference to pain management in Patient B's chart is in a progress note dated  
8 February 2, 2018, and states, "consider pain management." Pain management is again mentioned  
9 in a progress note dated January 2, 2019, and again on or about April 4, 2019. Respondent  
10 remained the sole prescriber of Patient B's opiate medications.

11 72. A progress note in Patient B's chart dated May 14, 2018, references a diagnosis of  
12 "sleep apnea – mild." Pain medications often worsen apneic episodes during sleep and would  
13 have magnified Patient B's respiratory risks. The diagnosis of sleep apnea did not lead to any  
14 marked tapering by Respondent of Patient B's opiate medications.

15 73. Patient B's chart does not reflect that Respondent attempted to taper her opiates by  
16 rotation to different opiates.

17 74. The only prescription for Naloxone found in Patient B's chart is dated January 15,  
18 2018, for one nasal spray 4 mg with two (2) refills.

19 75. There are no vital signs recorded in Patient B's chart throughout the period reviewed.

20 76. A progress note in Patient B's chart dated January 3, 2017, documents the reason for  
21 the visit as "here for follow up of the swollen lymph nodes." The note does not indicate which  
22 lymph nodes were swollen and contains no details of a physical examination.

23 Patient C.<sup>8</sup>

24 77. Patient C is an adult male born in 1985. He received care and treatment from  
25 Respondent for shoulder pain due to rotator cuff injury, chronic low back pain (that "came and  
26 went") due to degenerative disc disease, and management of diabetes.

27  
28 <sup>8</sup> Records reviewed for Patient C cover the period November 20, 2015, through June 1,  
2019 ("the Patient C period reviewed").

1 78. A CURES report for Patient C shows that, prior to becoming Respondent's patient, he  
2 filled prescriptions issued by a different provider for oxycodone (10 mg per day), on or about  
3 July 15, 2014, August 5, 2014, and September 2, 2014. When Respondent assumed the care of  
4 Patient C, she escalated Patient C's opiate dosage: on or about October 28, 2014, Respondent  
5 issued Patient C a prescription for oxycodone 10 mg x 60, and seven days later, on or about  
6 November 5, 2014, another prescription for oxycodone 10 mg x 180.

7 79. Between October 28, 2014, and January 25, 2015 (90 days), Patient C filled  
8 prescriptions issued by Respondent for oxycodone 10 mg x 600 tablets<sup>9</sup> and carisoprodol 350 mg  
9 x 180 tablets.

10 80. On or about January 26, 2015, Patient C filled prescriptions from Respondent for  
11 oxycodone 10 mg x 180, and nine (9) days later, on or about February 4, 2015, a prescription  
12 from Respondent for oxycodone 15 mg x 180. Between February 4, 2015, and June 16, 2015  
13 (133 days), Patient C filled prescriptions from Respondent for oxycodone 15 mg x 1,040.<sup>10</sup>

14 81. From on or about June 17, 2015, Patient C started filling monthly prescriptions from  
15 Respondent for an increased dose of oxycodone (30 mg x 120 tablets), and also started filling  
16 monthly prescriptions for morphine sulfate 30 mg x 90 tablets. This represented a consistent  
17 MEDD of 270 mg.

18 82. On or about April 11, 2016, Respondent increased the morphine sulfate to 60 mg x 90  
19 tablets per month, raising the MEDD from 270 mg to a consistent 360 mg for at least the ensuing  
20 3.5 years.

21 83. For the five year period from June 17, 2015, through at least July 1, 2020,<sup>11</sup>  
22 Respondent prescribed Patient C a combination of oxycodone 30 mg x 120 per month, and  
23 MS Contin 30 mg or 60 mg (as indicated above) x 90 per month.

24 ////

25 ////

26  
27 <sup>9</sup> An average of 6.67 x oxycodone 10 mg tablets per day.

<sup>10</sup> An average of 7.8 x oxycodone 15 mg tablets per day.

28 <sup>11</sup> A CURES report was obtained for Patient C, ending July 1, 2020.

1       84. From November 21, 2014, through at least July 1, 2020, Respondent also prescribed  
2 carisoprodol 350 mg x 90 per month as a muscle relaxant for Patient C's low back pain, to be  
3 taken concurrently with the oxycodone and morphine sulfate as indicated above.<sup>12</sup>

4       85. Patient C's chart contains no imaging results or surgical consultations for  
5 confirmation of either Patient C's rotator cuff complaint or of his degenerative spine, or the  
6 severity of either complaint.

7       86. The first documentation of the pain intensity scale in the Patient C period reviewed is  
8 found in the progress note dated November 17, 2016, with the comment, "Meds work well, get  
9 pain down to about a 4/10." The pain medications were not decreased.

10       87. The first documentation of any toxicology testing of Patient C is found in the progress  
11 note dated January 9, 2017. Patient C's chart for the entire period reviewed shows four (4) drug  
12 toxicology tests.<sup>13</sup>

13       88. No CURES queries are documented in Patient C's chart.<sup>14</sup> A CURES report for  
14 Patient C reveals that he was prescribed Suboxone 8 mg-2 mg x 60 tablets on April 12, 2018, and  
15 again on April 17, 2018, by a provider other than Respondent. Respondent was unaware of these  
16 prescriptions and failed to recognize possible opiate addiction in Patient C.

17       89. On or about September 7, 2018, Respondent "offered" Narcan to Patient C for  
18 prevention of opiate toxicity or potential drug overdoses; however, no prescriptions for Narcan  
19 can be found in Patient C's chart for the period reviewed.

20       90. On or about April 11, 2016, Respondent noted in Patient C's chart that his primary  
21 care physician should refer him to pain management and orthopedics. Respondent did not initiate  
22 the consultations and Patient C's chart makes no reference to whether these referrals were ever  
23 given or acted upon.<sup>15</sup>

24       ////

25       <sup>12</sup> The first morphine sulfate prescription was filled on or about June 17, 2015.

26       <sup>13</sup> On or about January 9, 2017, March 9, 2018, December 14, 2018, and May 17, 2019.

27       <sup>14</sup> At an interview with Respondent on or about August 18, 2020 ("the second subject  
28       interview"), Respondent stated she "was accustomed to checking CURES and ... doing drug tests  
and often did not write it down..."

<sup>15</sup> At the second subject interview, Respondent stated Patient C did not receive these  
referrals since he did not have insurance.

1        91. On or about May 30, 2016, Respondent referred Patient C to home physical therapy  
2 exercises and considered the possibility of acupuncture therapy, while continuing Patient C on the  
3 same dosage of narcotics. Respondent did not initiate any acupuncture referral or follow through  
4 with a trial of acupuncture therapy.

5        92. On or about August 2, 2016, Respondent referred Patient C to UCSD mental health  
6 clinic for management of his anxiety<sup>16</sup>. A prescription for alprazolam 0.5 mg was added in  
7 February 2019, but Patient C's chart does not reflect that he received any psychiatric help from  
8 August 2016 through the remainder of the Patient C period reviewed.

9        93. On or about June 12, 2017, Respondent referred Patient C to an otolaryngologist (ear,  
10 nose and throat physician) and for a polysomnogram for evaluation of obstructive sleep apnea.  
11 Patient C's chart contains no consultation notes or sleep study results and it is not clear if he was  
12 fully evaluated for this condition.

13        94. Respondent did not taper Patient C's opiate usage in light of the clinical concern for  
14 obstructive sleep apnea, and continued prescribing him three controlled substances that suppress  
15 respiration (namely, oxycodone, morphine sulfate, and carisoprodol).

16        95. On or about February 15, 2019, Respondent noted in Patient C's chart that she was  
17 discontinuing carisoprodol and starting alprazolam 0.5 mg for anxiety. Two prescriptions of 20 x  
18 0.5 mg tablets were written by Respondent on or about February 15, 2019, and filled by Patient C  
19 in May 2019.

20        96. Carisoprodol prescriptions were filled in March 2019 and again on a monthly basis  
21 from May 2019 onwards. Patient C's chart does not reflect the effect of the alprazolam tablets on  
22 Patient C's anxiety, or why they were apparently stopped and the carisoprodol resumed.

23        97. There are no vital signs (and weight) recorded in Patient C's chart for the entire  
24 period reviewed. At the second subject interview, Respondent stated that she "was not  
25 accustomed to taking vital signs unless it was necessary for what [she] was doing.... [She]  
26 occasionally... would do the blood pressure, checking that it wasn't too low."

27 \_\_\_\_\_  
28 <sup>16</sup> Worsening anxiety and panic attacks experienced by opiate dependent patients are often  
warning signs of opiate withdrawal and physical dependency.

1 98. During the Patient C period reviewed, Respondent did not try non-opiate medications  
2 such as tricyclic antidepressants or anti-seizure medications, or the use of safer muscle relaxants  
3 and topical analgesic creams concurrently with the opiate therapy.

4 99. Patient C's chart does not show an adequate risk assessment of Patient C nor a  
5 recognition by Respondent that Patient C had elevated addiction risks due to his anxiety disorder,  
6 young age, and male sex.

7 100. Respondent's care and treatment of Patient C shows no recognition of Patient C's  
8 development of opiate tolerance (based on the high opiate dosage he required daily), and she did  
9 not taper down his narcotics or rotate to different opiate medications.

10 101. Many progress notes in Patient C's chart had no physical examination findings or  
11 functional assessments to justify Patient C's high opiate dosage. The records also do not include  
12 the components of an adequate diabetic management, including annual eye examinations and feet  
13 examinations, and regular blood monitoring.

14 102. A prescription for Lexapro (with five (5) refills) dated May 17, 2019, is contained in  
15 Patient C's chart. Respondent's progress notes for Patient C make no mention of this medication.

16 103. Respondent issued prescriptions for Patient C for ibuprofen 800 mg x 90 tablets in  
17 November 2015, January 2016, January 2018, and February 2019.

18 Patient D:

19 104. Patient D is a female adult born in 1986, who suffered from multiple medical  
20 illnesses, including chronic granulomatous disease ("CGD"),<sup>17</sup> depression and anxiety, attention  
21 deficit disorder ("ADD"), cirrhosis, and chronic low back pains of unknown etiology.<sup>18</sup>

22 105. For at least the three and a half year period between December 30, 2015, and June 1,  
23 2019 ("the Patient D period reviewed")<sup>19</sup> and continuing until at least July 1, 2020,<sup>20</sup> Respondent

24 <sup>17</sup> Chronic granulomatous disease ("CGD") is a genetic disorder that causes the immune  
25 system to malfunction, resulting in a form of immunodeficiency and leading to recurrent  
26 infections and inflammations of the body. Chronic pain syndrome is a potential complication of  
27 this disease.

28 <sup>18</sup> Due to Patient D's high risk of recurrent infections, spinal inflammation was a potential  
source of her back pains.

<sup>19</sup> Respondent started treating Patient D before 2015, possibly as early as 2012.

<sup>20</sup> A CURES report was obtained for Patient D, ending July 1, 2020.

1 consistently prescribed to Patient D a combination of Morphine SR 180 mg and oxycodone 330  
2 or 360 mg daily, amounting to an MEDD of approximately 720 mg.<sup>21</sup> During the same period,  
3 Patient D also consistently received from Respondent alprazolam 6 mg daily (for her long-term  
4 anxiety disorder) and Adderall 60 mg daily (for ADD).

5 106. Patient D saw Respondent on two occasions during the calendar year 2016 (August  
6 and December), and four times in 2017 and 2018, respectively.

7 107. Respondent listed chronic granulomatous disease as the main indication for long-term  
8 pain management of Patient D, but her chart is frequently silent on the specific source(s) of the  
9 pain and their association with CGD. In February 2019, there are references in Patient D's chart  
10 to pancreatitis, pyelonephritis and kidney stones. These painful conditions were likely evaluated  
11 during Patient D's hospital stays for recurrent infections, but the hospital records were not  
12 contained in Patient D's chart.

13 108. An MRI of Patient D's back was ordered in July 2017, but no report is found in  
14 Patient D's chart and no results are documented in the notes.

15 109. During the Patient D period reviewed, Respondent made (unsuccessful) documented  
16 attempts to taper down Patient D's narcotic dosage. No attempt was made to manage Patient D's  
17 chronic pain syndrome through an outpatient multi-disciplinary approach, including surgical  
18 consultations with orthopedics for back pains, urology for kidney stones, medical consultations  
19 with gastroenterology for pancreatitis, anesthesiology for nerve blocks and ablation, pain  
20 management consultations, and primary care coordination of ancillary treatments like weight loss,  
21 acupuncture, and chiropractic adjustments.

22 110. Patient D's chart shows no trials of tricyclic medications, anti-seizure medications,  
23 muscle relaxants, and/or topical therapies, to try to reduce Patient D's dependency on high dose  
24 narcotics.

25 111. Respondent recommended and referred Patient D to mental health providers in  
26 November 2018 to better manage her depression and anxiety. It is unknown whether Patient D  
27

28 <sup>21</sup> A prescriber CURES report for Respondent, starting in August 2015, shows that Patient D was filling similar prescriptions issued by Respondent as early as August 2015.

1 complied with the recommendation, as the chart contains no consultation reports or  
2 documentation of any conversations with any mental health providers.

3 112. Patient D's chart shows only two documented drug toxicology tests for the entire  
4 period reviewed. The chart contains one CURES report dated December 30, 2015 (covering the  
5 calendar year 2015), and one dated May 11, 2016 (covering the prior six month period, starting  
6 November 11, 2015).

7 113. Patient D's chart shows no risk assessment of Patient D (including documentation of  
8 her social history and issues such as smoking and/or alcoholism, which increase addiction risks),  
9 or an appreciation by Respondent that Patient D had elevated addiction risks due to her youth and  
10 psychiatric conditions.

11 114. Patient D's chart shows no appreciation or recognition by Respondent of Patient D's  
12 opiate tolerance and the inherent risks from a narcotic dosage of 720 mg MEDD. Respondent did  
13 not taper down Patient D's narcotic prescriptions or rotate to different opiate medications if  
14 needed.

15 115. Respondent also provided stimulant Adderall therapy of 60 mg daily to Patient D  
16 during the entire period reviewed, for treatment of her ADHD.<sup>22</sup> Patient D's chart for the period  
17 reviewed contains no documentation to confirm the diagnosis, or evidence of a clinical  
18 assessment or attempt to reduce Patient D's Adderall dosage.<sup>23</sup>

19 116. Respondent's progress notes for Patient D are sparsely notated. No vital signs  
20 (including blood pressure and weight) were recorded in Patient D's chart throughout the period  
21 reviewed, and there is no (or insufficient) documentation of the "five A's" of chronic pain  
22 management, or of thorough physical examinations and functional assessments. No consultation  
23 reports are contained in Patient D's chart for the period reviewed.

24 ////

25 ////

26  
27 <sup>22</sup> A CURES report found in Patient D's chart for the calendar year 2015 shows that  
Patient D was receiving this dose of Adderall as early as January 2015.

28 <sup>23</sup> Adderall's side effects include worsening of anxiety, elevations in blood pressure and  
heart rate, and arrhythmias.

Patient E:

117. Patient E is an adult male born in 1985, whose primary complaint was knee pain. He received care and treatment from Respondent from 2014 through 2018.

118. From July 2015 through January 2018 ("the Patient E period reviewed"),<sup>24</sup> Respondent prescribed a combination of hydrocodone 325/10 mg and oxycodone 325/10 mg concurrently, with intermittent tramadol 50mg,<sup>25</sup> for Patient E's knee pain. Respondent also prescribed morphine sulphate 30 mg, and morphine sulphate 60 mg, for Patient E on one occasion.

119. For the entire 2016, Patient E averaged approximately 120 mg MEDD with intermittent Tramadol tablets.

120. For the entire 2017, Patient E averaged approximately 73 mg MEDD.

121. During the entire Patient E period reviewed, Respondent obtained no imaging or surgical evaluation of Patient E's chronic knee pains.

122. Respondent conducted minimal physical examination of Patient E's knee(s). The following are the entirety of the documented knee examinations in Patient E's chart during the period reviewed:

August 13, 2015: "PE – Left knee with tenderness, crepitus; No instability"

September 28, 2015: "PE Knewws [sic] with crepitus"

October 12, 2015: "PE – knee with crepitus, decreased range of motion"

July 6, 2016: "PE – ... Neg straight leg raise"

July 11, 2016: "PE – left knee with crepitus; Decreased flexion"

September 6, 2016: "PE – left knee with crepitus"

October 12, 2016 "PE – left knee effusion; Tenderness at patella; Decreased flexion; limping"

////

////

<sup>24</sup> Records reviewed for Patient E cover the period July 1, 2015, through January 2018.

<sup>25</sup> The most recent fill date for tramadol appears to have been September 23, 2016.

1 February 20, 2017: "PE – left knee with crepitus; No instability, neg ant drawer test;<sup>26</sup>  
2 Tender medially"

3 April 17, 2017: "PE – left knee with some swelling; No frank effusion; + crepitus"

4 July 20, 2017: "PE – left knee with crepitus, tenderness at patella; Some pain medially on  
5 palpation"

6 January 4, 2018: "PE – left knee with small effusion, swelling of medial bursa"

7 123. Patient E's chart for the period reviewed showed no treatments from orthopedics or  
8 pain management services.

9 124. During the Patient E period reviewed, Respondent made no recommendations for  
10 physical or acupuncture therapy, or for chiropractic adjustments.

11 125. During the Patient E period reviewed, Respondent recommended no medications like  
12 NSAIDS or tricyclic antidepressants or anti-seizure medications, cognitive behavior therapies or  
13 topical therapies. Patient E's pain was managed entirely by Respondent, based on narcotic  
14 therapy.

15 126. Patient E's chart for the period reviewed showed drug toxicology testing on two  
16 occasions, namely, July 2016 and April 2017.

17 127. Respondent's progress notes for Patient E are sparsely notated. No vital signs were  
18 recorded in Patient E's chart throughout the period reviewed, and there is no documentation of  
19 the "five A's" of chronic pain management. The chart contains no CURES reports.

20 Patient F:

21 128. Patient F is a male minor child born in September 2010.

22 129. On or about May 17, 2016, the mother of Patient F emailed Respondent, introducing  
23 herself and explaining that she was looking for a doctor "to help [her] with getting a child a  
24 medical exemption ..." Between on or about May 17, 2016, and August 23, 2016, Patient F's  
25 mother and responded emailed back and forth regarding a vaccine exemption for Patient F and  
26

27 <sup>26</sup> Negative anterior drawer test. The anterior drawer test is a physical examination that  
28 may be used to test the stability of the knee's anterior cruciate ligament (ACL). If the anterior  
drawer test is positive, and the ligaments are not as supportive as they should be, a person may  
need a variety of treatments based on the severity of their injuries.

1 obtaining what Respondent considered to be relevant family history for this exemption.  
2 Respondent advised Patient F's mother to "look at [Respondent's] webpage [on vaccine  
3 exemptions] for ideas."

4 130. Finally, by email dated August 23, 2016, Respondent wrote to Patient F's mother:

5 "Yes! Fantastic! That is exactly what we needed !!!

6 1. Dad – food allergies, psoriasis (dad wrote his own letter) – documented  
7 ([grandmother] confirmed)

8 2. Mom – food allergies - documented

9 3. [Patient F] – eczema/rash, food allergies – DOCUMENTED

10 4. Aunt ... - psoriasis – documented

11 5. Cousin – celiac"

12 I have put you down as qualified and documented. ..."

13 Apart from Patient F, the family members' medical histories are "documented" only by  
14 letters or reports from family members. Their "food allergies" are not formal diagnoses of  
15 allergy, but rather that the family gets "bad physical side effects after eating wheat[,] dairy and  
16 soy." Patient F's father reportedly "had a bad reaction to a vaccine when he was a kid... [H]is  
17 mother said he had mini seizures after he got vaccinated." Patient F's mother informed  
18 Respondent that she has "had digestive issues my whole life due to food allergies."

19 131. Patient F suffered from asthma, and was said by his mother to get "chronic coughs  
20 any time he eats certain foods... He also gets eczema and a skin rash around his mouth."  
21 Respondent's chart for (the then almost six year old) Patient F does not include any record or note  
22 regarding whether or not he had received any prior vaccines.

23 132. Respondent saw Patient F at one visit, a group visit, on or about August 25, 2016. A  
24 physical exam was documented in Patient F's chart with a checklist, and "const" (constitutional",  
25 eyes, "ENT/mouth" and neck were all checked off as "WNL." A superbill for this visit included  
26 detailed visit (99203) and the family was charged \$120.

27 133. Respondent prepared a document dated August 26, 2016, providing Patient F with a  
28 permanent medical exemption from all vaccines on the Center for Disease Control and  
Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

[Patient F] DOB 9/[xx]/10 has a strong family history of hyperimmune  
conditions like food allergies, and autoimmune diseases like Celiac and Psoriasis in  
multiple generations. Given this level of immune dysfunction in the family history, I

1 feel he is at a high risk of adverse reaction to vaccines. If there is an imminent  
2 medical threat in the community we can consider a single vaccine in a controlled  
3 medical environment, however, the benefits to him and the community must greatly  
4 outweigh his very real personal risk. I would recommend skin testing to the vaccine  
5 and all its additives prior to injection. This medical exemption for vaccines is  
6 permanent. It includes, but is not limited to, DtaP [sic], TdaP, Polio, Varicella,  
7 MMR, Hep B and A, HPV, HiB, Flu and Meningitis and includes all current vaccines  
8 on the CDC recommended vaccine list and any future vaccines placed on the list.

9 134. Respondent maintains a website with a page dedicated to vaccines. On it, she makes  
10 statements that include the following:

11 ... The standard vaccine schedule is now being disputed by many pediatricians,  
12 including yours truly, because it recommends too many shots all at once, especially at  
13 the one year mark, which is when the measles vaccine (MMR) is first given. ...  
14 Children with hyper immune systems, such as those with eczema or food allergies, do  
15 not handle that many shots well. Because of this, many pediatricians are advocating  
16 for a slower schedule. ...

17 I feel [the Hepatitis B vaccine] is not needed [for newborns or infants] until  
18 they are at risk of being bitten - like at daycare with toddlers - or as a teen. If you test  
19 negative for Hepatitis B, then you can choose to do the standard schedule or you can  
20 do them at 2 years old or as a teen. ...

21 A very interesting fact is that [the Chicken Pox vaccine] may have eliminated a  
22 natural immunity boost against Shingles. . . . Without children getting chicken pox,  
23 parents and grandparents are now getting shingles. [The Chicken Pox] vaccine  
24 created the need for [the Shingles] vaccine.

25 [The HPV<sup>27</sup> vaccine] is now recommended for boys, since they transmit to the  
26 girls, but I feel this is overstepping the parameters of the vaccine. ...

27 One last important point: Unvaccinated children are really only a risk to other  
28 unvaccinated children, and only if ill...

135. In fact, Respondent's statement that children cannot handle multiple immunizations is  
false and unsupported by any data. By not recommending the Hepatitis B vaccine routinely,  
Respondent ignores that there are Hepatitis B cases that are cryptogenic (that is, of uncertain  
origin, or no source is identified). Shingles is actually prevented by the primary chicken pox  
vaccine, and Respondent's lack of support for HPV vaccinations for boys shows she does not  
understand HPV transmission and the risk of oropharyngeal cancer to both sexes.

136. Respondent's rationale for providing the vaccine exemption to Patient F is that, in her  
view, patients with family members with asthma, allergies or psoriasis will be at risk of  
"overreaction" to vaccinations. In fact, patients with allergies (for instance, asthma or eczema)

<sup>27</sup> Human papillomavirus.

1 are at greater risk from the vaccine preventable diseases (for instance, influenza in the case of  
2 patients with asthma, and varicella in the case of patients with eczema), so that vaccine is highly  
3 recommended in these patients, not contraindicated or cautioned against.

4 137. Providing Patient F with an exemption from all vaccinations, current and future, on  
5 this basis was not consistent with, and was in direct opposition to, the recommendations of the  
6 CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies.

7 138. Respondent's recommendation of "skin testing to the vaccine and all its additives  
8 prior to [vaccination]" is not a reasonable or scientific approach to managing vaccination in a  
9 child with a history of allergies.

10 Patient G:

11 139. Patient G is a male minor child born in October 2005.

12 140. On or about January 21, 2017, Patient G's mother wrote to Respondent, inquiring  
13 about a vaccine exemption for Patient G, then 11 years old, who suffered from asthma and  
14 allergies.

15 141. On the same day, Respondent replied:

16 "Unfortunately, asthma requires more vaccines ... not fewer... However, if we  
17 can prove the immune systems of many in the family are over active, then we can  
18 show that it is likely he inherited the problem also, as evidenced by his asthma, and  
therefore he is more likely to have a bad reaction to a vaccine..."

19 142. Respondent then referred Patient G's mother to her webpage on vaccine exemptions:

20 "[S]ee the list of all the diseases that can help him qualify. ... Then email me  
21 who has what diseases in the family and their documentation. I am doing all  
22 preliminary qualifying and gathering of documents by email, and only schedule a  
one-time Group appointment when I have all documentation..."

23 143. Finally, Respondent found there to be sufficient documentation, and noted in  
Patient G's chart:

- 24 1. [Patient G] – allergies – DOCUMENTED
- 25 2. [Grandmother] – asthma – DOCUMENTED
- 26 3. [Aunt] – Hashimotos – DOCUMENTED
- 27 4. [Grandfather] – type 1 [diabetes mellitus] – DOCUMENTED

28 ////

1 144. On or about February 8, 2017, Respondent wrote:

2 "GOOD JOB!

3 I have put you down as qualified and documented!

4 My next Group visit for the medical exemptions will be in March. I will email  
5 with details soon.

6 If you require something for school before that time, let me know and I can  
7 write a promise of appointment letter."

8 145. Patient G's mother wrote to Respondent on or about February 9, 2017, saying she was  
9 impatient for an appointment earlier than March. Respondent explained that she had "a very busy  
10 regular practice, and 75 people ahead of [Patient G] on the list." The "group appointment"  
11 allowed Respondent to see thirty people in one day. Respondent then forwarded a "promise of an  
12 exemption" letter for Patient G (dated February 7, 2017) to his mother. The letter, addressed "To  
13 whom it may concern," stated the following:

14 [Patient G] has an appointment in March for an evaluation of his immunization  
15 status. I certify that he is fully qualified per California law SB277 for a medical  
16 exemption to vaccines. I have full medical documentation in my possession upon  
17 which I base this determination. I am currently waiting for my schedule to  
18 accommodate his appointment. The appointment is guaranteed, at which time I will  
19 formally write the medical exemption according to law and dept. of Public Health  
20 regulations. The exemption will be permanent and include DtaP [sic], Tdap, MMR,  
21 Polio, Varicella, Hib, PCV, Meningitis and Hepatitis A and B. Thank you for  
22 understanding the scheduling difficulties of this time of year, especially with the new  
23 law in place. Please contact me if you have further questions.

24 146. Respondent did not obtain or review Patient G's past medical records, including  
25 previous vaccine records.

26 147. Respondent saw Patient G at one visit, on or about March 7, 2017, at a group visit. A  
27 physical exam was documented in Patient G's chart with a checklist, and "const" (constitutional",  
28 eyes, "ENT/mouth" and neck, were all checked off as "WNL." A superbill for this visit included  
detailed visit (99203) and the family was charged \$120.

1 148. On or about March 7, 2017, Respondent prepared a document providing Patient G  
2 with a permanent medical exemption from all vaccines on the Center for Disease Control and  
3 Prevention's ("CDC") recommended list as well as from any future vaccines placed on the list:

4 [Patient G] DOB 10/[xx]/05 has a very strong family history of hyperimmune  
5 reactions, and autoimmune diseases like Hashimotos Disease. Given this, I feel he is  
6 at a high risk of adverse reaction to vaccines. If there is an imminent medical threat in

1 the community we can consider a single vaccine in a controlled medical environment;  
2 however, the benefits to him and the community must greatly outweigh his very real  
3 personal risk. This medical exemption for vaccines is permanent. It includes, but is  
not limited to, DtaP<sup>28</sup> [sic], Tdap, Polio, Varicella, MMR, Hep B and A, HIB, PCV,  
HPV, Influenza, and Meningitis, and includes all current vaccines on the CDC list.

4 149. Respondent's rationale for providing the vaccine exemption to Patient G is that, in her  
5 view, patients with family members with "a family history of overreactions ... and autoimmune  
6 diseases" placed Patient G at higher risk of an adverse reaction to vaccines. In fact, a family  
7 history of allergic or autoimmune conditions does not make a vaccine reaction more likely in the  
8 child.

9 150. Providing Patient G with an exemption from all vaccinations, current and future, on  
10 this basis was not consistent with, and was in direct opposition to, the recommendations of the  
11 CDC, American Academy of Pediatrics ("AAP"), and/or other guiding bodies.

12 Patients H and I:

13 151. Patient H is a female minor child born in January 2010. Her sibling, Patient I, is a  
14 male minor child born in August 2013.

15 152. On or about December 5, 2018, the siblings' mother emailed Respondent in  
16 connection with obtaining vaccine exemptions for Patient H and Patient I. She provided  
17 documentation in substantiation of the children's "qualifying disease," namely, asthma.

18 153. On or about December 17, 2018, Respondent responded, "Good work!" In her email,  
19 she informed the mother that the next "Group Visit" appointment would be on January 9, 2019,  
20 and that "one person receiving the exemption should be present. If a child or a family, then only  
21 one parent and one child needs to be present." In addition, if "something for school" was  
22 required before the appointment, Respondent offered to write a "promise of appointment letter."

23 154. Respondent saw Patient H and Patient I at one visit, on or about January 9, 2019, at a  
24 group visit. At an interview during the Board's investigation into this matter, Respondent

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26  
27 <sup>28</sup> Due to his age, Patient G was not eligible for DTaP or Hib. These are not administered  
28 to children older than 7 and 4 years of age, respectively. Further, if Patient G had already  
received some vaccines, he may not have needed to receive additional vaccines for MMR,  
varicella, or hepatitis A and B.

1 explained that she used the children's asthma action plans and their mother's inhaler prescription  
2 to verify the "over reactive" immune system of Patient H and Patient I.

3 155. Respondent's chart for Patient H contains a documented physical exam with a  
4 checklist that has "const" (constitutional), eyes, "ENT/mouth" and neck, all checked off as being  
5 "WNL." No vital signs are recorded. A superbill for this group visit indicates it was a "detailed"  
6 visit for which the family was charged \$120. Respondent's chart for Patient I contains an almost  
7 identical checklist, with additional check marks at "Resp" and "CV." No vital signs are recorded.  
8 A superbill for this group visit indicates it was a "minimal" visit for which the family was again  
9 charged \$120.

10 156. Respondent did not obtain or review Patient H or Patient I's past medical records.

11 157. In fact, Patient H's medical records from her primary care provider show that Patient  
12 H had received multiple prior vaccines and her primary care physician did not regard her as  
13 having any medical condition that would warrant medical exemption.

14 158. A review of Patient I's medical records from his primary care provider show that, at  
15 two years of age, he had a hospital admission for RSV (Respiratory Syncytial Virus, a common  
16 respiratory virus) with asthma exacerbation. At four years of age, he had a pustule in his nostril  
17 that cultured positive for MRSA (methicillin-resistant Staphylococcus aureus, a type of bacteria  
18 that is resistant to several antibiotics). His primary care physician noted in his chart that she  
19 recommended Patient I receive vaccines consistent with AAP and CDC guidelines.

20 159. It is well established that children with asthma are at particularly high risk of  
21 complications from influenza infection, including pneumonia, respiratory failure, and even death.  
22 Additionally, Patient I – due to his MRSA colonization – was at increased risk of infectious  
23 complications (MRSA pneumonia) if infected with influenza, which constituted an additional  
24 reason to make sure he was protected from seasonal influenza.

25 160. On or about January 9, 2019, Respondent prepared a document providing Patient H  
26 and Patient I with identical permanent medical exemptions from all vaccines on the Center for  
27 Disease Control and Prevention's ("CDC") recommended list as well as from any future vaccines  
28 placed on the list:

1 [Patient name and date of birth] has a strong family history of hyperimmune  
2 conditions like anaphylaxis in multiple generations. Given the level of immune  
3 dysfunction in the family, I feel [s]he is at higher risk of adverse reaction to vaccines.  
4 If there is an imminent medical threat in the community we can consider a single  
5 vaccine in a controlled medical environment; however, the benefits to [her/him] and  
6 the community must greatly outweigh [her/his] very real personal risk. This medical  
7 exemption for vaccines is permanent. It includes, but is not limited to,  
8 DtaP/Tdap/Td/dT, Polio, MMR, Varicella, Hep B and A, HIB, PCV, HPV, Influenza,  
9 and Meningitis, and includes all current vaccines on the CDC recommended vaccine  
10 list and any future vaccines placed on the list.

#### 11 **FIRST CAUSE FOR DISCIPLINE**

##### 12 **(Gross Negligence)**

13 161. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined  
14 by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care  
15 and treatment of Patient A, Patient B, Patient C, Patient D, Patient F, Patient G, Patient H and  
16 Patient I, as more particularly alleged hereinafter:

##### 17 **Patient A:**

18 162. Paragraphs 44 through 58, above, are hereby realleged and incorporated by this  
19 reference as if fully set forth herein.

20 163. Respondent committed gross negligence in her care and treatment of Patient A in  
21 granting a permanent vaccine exemption for Patient A based on a remote and irrelevant family  
22 medical history.

##### 23 **Patient B:**

24 164. Paragraphs 44, and 59 through 76, above, are hereby realleged and incorporated by  
25 this reference as if fully set forth herein.

26 165. Respondent committed gross negligence in her initiation and/or monitoring of  
27 Patient B's chronic opiate pain medications, including, but not limited to, her failure to recognize  
28 Patient B's opiate tolerance sooner, her inadequate clinical assessment(s) of Patient B's pain and  
functionality, the inadequate tapering process, Respondent's failure to prescribe naloxone sooner,  
and her prescribing opiates to Patient B with an MEDD in excess of 1000 mg.

166. Respondent committed gross negligence by failing to maintain adequate and accurate  
records of her care and treatment of Patient B.

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1 Patient C:

2 167. Paragraphs 44, and 77 through 103, above, are hereby realleged and incorporated by  
3 this reference as if fully set forth herein.

4 168. Respondent committed gross negligence in her initiation and/or monitoring of  
5 Patient C's chronic opiate pain medications, including, but not limited to, her lack of addiction  
6 risk assessment, lack of a multi-disciplinary pain management approach, fast escalation of  
7 narcotic dosage, failure to recognize opiate tolerance, failure to recognize opioid addiction, failure  
8 to taper down the opiate dosage, and/or lack of routine toxicology drug testing and CURES  
9 consultations.

10 Patient D:

11 169. Paragraphs 44, and 104 through 116, above, are hereby realleged and incorporated by  
12 this reference as if fully set forth herein.

13 170. Respondent committed gross negligence in her initiation and/or monitoring of  
14 Patient D's chronic opiate pain medications, including, but not limited to, an excessively high  
15 narcotic dosage and lack of tapering, her failure to recognize Patient D's opiate tolerance and  
16 failure to consult pain management in a complicated patient, lack of addiction risk assessment,  
17 and/or minimal drug toxicology testing and CURES consultations.

18 Patient F:

19 171. Paragraphs 44, and 128 through 138, above, are hereby realleged and incorporated by  
20 this reference as if fully set forth herein.

21 172. Respondent committed gross negligence in her care and treatment of Patient F in  
22 granting a permanent vaccine exemption for Patient F based on a remote and irrelevant family  
23 medical history.

24 Patient G:

25 173. Paragraphs 44, and 139 through 150, above, are hereby realleged and incorporated by  
26 this reference as if fully set forth herein.

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28 ////

1 174. Respondent committed gross negligence in her care and treatment of Patient G in  
2 granting a permanent vaccine exemption for Patient G based on a remote and irrelevant family  
3 medical history.

4 *Patients H and I:*

5 175. Paragraphs 44, and 151 through 160, above, are hereby realleged and incorporated by  
6 this reference as if fully set forth herein.

7 176. Respondent committed gross negligence in her care and treatment of Patient H in  
8 granting a permanent vaccine exemption for Patient H based on an irrelevant family medical  
9 history.

10 177. Respondent committed gross negligence in her care and treatment of Patient I in  
11 granting a permanent vaccine exemption for Patient I based on an irrelevant family medical  
12 history.

13 **SECOND CAUSE FOR DISCIPLINE**

14 **(Repeated Negligent Acts)**

15 178. Respondent is further subject to disciplinary action under sections 2227 and 2234, as  
16 defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent  
17 acts in her care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, Patient F,  
18 Patient G, Patient H and Patient I, as more particularly alleged hereinafter:

19 179. Paragraphs 44 through 177, above, are hereby realleged and incorporated by this  
20 reference as if fully set forth herein.

21 180. Respondent also committed the following repeated negligent acts in her care and  
22 treatment of Patient B, Patient D, and Patient E:

23 (a) Respondent failed to consider and/or employ non-opiate treatments in conjunction  
24 with opiate management of Patient B.

25 (b) Respondent failed to obtain diagnostic evaluation of Patient C's chronic orthopedic  
26 pains and failed to make an adequate attempt at using non-opiate treatments or therapies to reduce  
27 Patient C's dependency on narcotics during the three-year period reviewed;

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1 (c) Respondent failed to ensure that Patient C received appropriate psychiatric care and  
2 management by mental health experts before trying low dose alprazolam therapy (in combination  
3 with Patient C's long term opiate therapy), and/or failed to taper Patient C's opiate dosage in light  
4 of his worsening anxiety and panic attacks (which are often warning signs of opiate withdrawal  
5 and physical dependency);

6 (d) Respondent failed to maintain adequate and accurate documentation of her care and  
7 treatment of Patient C.

8 (e) Respondent failed to offer concurrent non-opiate therapy to Patient D to attempt to  
9 reduce her dependency on high dose opiates;

10 (f) Respondent failed to ensure that Patient D received appropriate psychiatric care and  
11 management by mental health experts and/or prescribed alprazolam 6 mg daily combined with  
12 Patient D's long-term 720 mg MEDD, placing Patient D at risk for accidental overdose;

13 (g) Respondent failed to properly monitor Patient D's Adderall therapy;

14 (h) Respondent failed to maintain adequate and accurate documentation of her care and  
15 treatment of Patient D.

16 (i) Respondent failed to provide non-opiate treatment to Patient E and prescribed high  
17 dose narcotics without performing a thorough evaluation of Patient E's knee and knee pains  
18 and/or without a detailed functional assessment;

19 (j) Respondent failed to conduct a thorough and/or adequate risk assessment and  
20 monitoring of the therapeutic efficacy of the narcotic medications she prescribed to Patient E;

21 (k) Respondent failed to maintain adequate and accurate medical records of her care and  
22 treatment of Patient E.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Incompetence)**

3 181. Respondent is further subject to disciplinary action under sections 2227 and 2234, as  
4 defined by section 2234, subdivision (d), of the Code, in that she demonstrated incompetence in  
5 her care and treatment of Patient A, Patient F, Patient G, Patient H and Patient I, as more  
6 particularly alleged in paragraphs 44 through 58, and 128 through 160 above, which are hereby  
7 realleged and incorporated by this reference as if fully set forth herein.

8 **FOURTH CAUSE FOR DISCIPLINE**

9 **(Failure to Maintain Adequate and Accurate Records)**

10 182. Respondent is further subject to disciplinary action under sections 2227 and 2234, as  
11 defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records  
12 in her care and treatment of Patient B, Patient C, Patient D, and Patient E, as more particularly  
13 alleged in paragraphs 59 through 127, above, which are hereby realleged and incorporated by this  
14 reference as if fully set forth herein.

15 **FIFTH CAUSE FOR DISCIPLINE**

16 **(Unprofessional Conduct)**

17 183. Respondent is further subject to disciplinary action in that she has engaged in conduct  
18 which breaches the rules or ethical code of the medical profession, or conduct that is unbecoming  
19 to a member in good standing of the medical profession, and which demonstrates an unfitness to  
20 practice medicine, as more particularly alleged in paragraphs 44 through 182, above, which are  
21 hereby realleged and incorporated by this reference as if fully set forth herein.

22 **PRAYER**

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


25 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 71646,  
26 issued to Respondent Tara Alaina Zandvliet, M.D.;

27 2. Revoking, suspending or denying approval of Respondent Tara Alaina Zandvliet,  
28 M.D.'s authority to supervise physician assistants and advanced practice nurses;

1           3.    Ordering Respondent Tara Alaina Zandvliet, M.D., if placed on probation, to pay the  
2 Board the costs of probation monitoring; and

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

4  
5 DATED: SEP 09 2021

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