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

In the Matter of the First Amended Accusation Against: **Ahvie Herskowitz, M.D.** **Physician's and Surgeon's Certificate No. C 50117** **Respondent.**	**Case No.: 800-2017-039339**

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 23, 2021.

IT IS SO ORDERED: November 23, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

AHVIE HERSKOWITZ, M.D.,

Physician's and Surgeon's Certificate No. C 50117

Respondent.

Agency Case No. 800-2017-039339

OAH No. 2021030334

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on September 13 through 17 and 20 through 21, 2021, by videoconference.

Deputy Attorneys General Alice W. Wong and Hamsa M. Murthy represented complainant William Prasifka, Executive Director of the Medical Board of California.

Attorneys Marvin Firestone and Meghan Shiner represented respondent Ahvie Herskowitz, M.D., who was present for the hearing.

The matter was submitted for decision on September 21, 2021.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. C 50117 to respondent Ahvie Herskowitz, M.D., on June 5, 1998. At the time of the hearing, this certificate was active and was scheduled to expire on August 31, 2023.

2. Acting in her official capacity as Interim Executive Director of the Board, Christine J. Lally filed an accusation against respondent on January 14, 2020. Respondent requested a hearing. Lally filed a first amended accusation against respondent on May 20, 2020, and complainant William Prasifka later assumed responsibility as the Board's Executive Director.

3. As amended further at the hearing, the accusation alleges that respondent committed professional negligence, and failed to maintain adequate and accurate medical records, in treating two patients. Although the patients received different treatment, complainant alleges for both patients that respondent performed or obtained inadequate physical examinations, made inadequate disclosure of risks and benefits before securing patient consent to treatment, and kept inadequate records. Complainant seeks disciplinary action against respondent for these allegedly unprofessional acts.

Professional Experience

4. Respondent graduated from medical school in 1977. He completed residencies in anatomic pathology and internal medicine, and a fellowship in cardiology. Respondent is board-certified in internal medicine and anatomic pathology.

5. After completing his cardiology fellowship in 1986, respondent served until 1995 as a clinical faculty member at the Johns Hopkins Hospital. In addition to treating heart disease, he established a basic research laboratory focusing on autoimmunity and heart disease. He investigated the role of inflammation in heart disease, and immunological challenges in heart transplantation.

6. Respondent moved to California in 1995. He served for four years at an organization conducting research and clinical trials regarding ischemia. Respondent then joined the clinical cardiology faculty at the University of California, San Francisco, and also served as a consulting cardiologist at the San Francisco Veterans' Administration Medical Center.

7. Between 2000 and 2010, in addition to his clinical practice, respondent served as an executive at two nonprofit pharmaceutical companies. Both companies conducted drug and device development for neglected diseases worldwide.

8. Respondent established a private practice he calls Anatara Medicine in 2010. This outpatient clinic focuses on integrative and complementary medical treatments. Respondent resigned his faculty position at the University of California, San Francisco, in 2014, to focus on his private outpatient practice.

9. Since 2018, respondent has been the president of the American College for Advancement in Medicine, a professional organization for health care providers practicing integrative medicine.

Patient 1

10. Patient 1 sought treatment from respondent in early August 2015, when Patient 1 was 71 years old. Patient 1 had suffered chronic head, neck, shoulder, and back pain for more than 25 years, since a workplace accident in 1988.[1]

11. Patient 1 had received medical treatment for his neck injury. He underwent surgical fusion of three cervical vertebrae in late 1990. He eventually developed degenerative damage to the vertebral discs above and below the fused vertebrae, causing further head, neck, and upper extremity pain.

12. When Patient 1 saw respondent, Patient 1 reported that his "primary care physician" was Dr. Leo Chi, and that he also regularly saw Dr. Ravi Panjabi, a pain management specialist. Dr. Panjabi had performed a nerve ablation procedure to Patient 1's cervical spine about a year before Patient 1 consulted respondent, and more recently had recommended trial of a "neuro-stimulation therapy." Patient 1 came to respondent to investigate whether any other treatment might be effective.

PHYSICAL EXAMINATION

13. Respondent's medical records state that his then-colleague Carine Bonnist, N.D., consulted first with Patient 1 on August 4, 2015. According to respondent's note, Bonnist spent about 60 minutes with Patient 1. Bonnist interviewed Patient 1 and prepared detailed notes regarding his neck injury and treatment history.

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[1] Patient 1 also had other health concerns, but consulted respondent only about pain and mobility limitations relating to his neck injury.

Her objective physical examination notes state only, "Patient is A&Ox3,[2] WNWD.[3] He is not distressed, though appears uncomfortable and in pain."

14. Respondent testified that as Bonnist's supervisor, he had instructed her to perform complete physical examinations of new patients, and had seen her do them. For these reasons, he assumed on August 4, 2015, that Bonnist had conducted a complete physical examination on Patient 1, and had detected nothing inconsistent with Patient 1's self-report about his current condition or treatment history.

15. Respondent's own notes about his interaction with Patient 1 on August 4, 2015, also include no description of any examination of Patient 1's cervical spine. For example, they do not indicate Patient 1's range of motion in any direction; they do not indicate where, if anywhere, Patient 1 reported pain with palpation; they do not indicate that respondent used any tests to identify motor or sensory neurological deficits; and they do not report any examination of the vascular system in Patient 1's head and neck.

16. Respondent testified that Patient 1 showed muscle atrophy in his arms, and poor grip strength, because of permanent damage to nerves connecting his cervical spine to his arms and hands. He testified further that Bonnist had observed, and reported to him about, these relevant conditions. Respondent's medical records do not indicate either arm atrophy or poor grip strength for Patient 1, and

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[2] All medically trained witnesses understood this shorthand to mean "alert and oriented to person, place, and time."

[3] All medically trained witnesses understood this shorthand to mean "well nourished and well developed."

respondent's description in testimony is inconsistent with Bonnist's notation that Patient 1 was "well developed."

SUBCUTANEOUS INJECTION THERAPY

17. Patient 1's medical record includes a two-page document titled, "Informed Consent and Request for Care." Patient 1 signed this document at his first office visit on August 4, 2015. Respondent testified, credibly but without corroboration, that Patient 1 signed this document after having conferred with respondent about the injection therapy described below in Finding 19.

18. The document described in Finding 17 states the patient's understanding that the patient has the opportunity to ask questions about diagnosis and care. It also states that the patient potentially may receive any of a long list of therapies, including "[t]rigger point injection therapy with vitamin substances." As "[p]otential benefits" of any of these treatments, but without correlating any particular benefit to any treatment, the document lists "[r]estoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression." As "[p]otential risks" of any of these treatments, again without correlating any particular risk to any treatment, the document lists "[p]ain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms."

19. Respondent's records regarding Patient 1's care on August 4, 2015, include these notes:

C6-C7 3-4cc AI + 18g – 5cc ozone

C7-T1 4cc AI + 18g – 8 cc ozone

Respondent testified that these notes indicate that he performed subcutaneous (not intramuscular) injections of a "prolozone" compound to areas in Patient 1's skin corresponding to the right-hand sides of the joints between the C6 and C7 vertebrae and the C7 and T1 vertebrae. He testified further that the prolozone compound includes a local anesthetic agent (either lidocaine or procaine), vitamin B12, and ozone, in a buffering solution.

20. Patient 1 returned to respondent for treatment on August 12, 2015, and August 19, 2015. Respondent's records from these visits include notes similar to his notes from August 4. On August 12 and August 19, according to respondent's testimony interpreting his notes, Patient 1 received subcutaneous injections of a prolozone compound to multiple skin locations near his cervical spine and to an area below and behind his ear, near the junction between his sternocleidomastoid muscle and his skull.

21. Nothing in Patient 1's records documents any explanation or discussion between respondent and Patient 1, on August 4, 2015, or on any other day, regarding specific potential risks and benefits to Patient 1 of any injection therapy, or regarding any comparison between therapeutic injections and other possible treatments for Patient 1's intractable pain.

22. Respondent testified that he recommended the injection therapy described in Findings 19 and 20 to Patient 1 as a short-term pain relief measure, and that they also discussed other treatments that could not occur immediately but that might improve the long-term condition of Patient 1's cervical spine. Respondent

testified as well that he explained to Patient 1 that subcutaneous prolozone injections might cause temporary soreness, bleeding, or bruising, but that they carried no risk of more serious or permanent adverse effects. In light of Patient 1's entire treatment record with respondent, this testimony is credible, though uncorroborated.

EXPERT TESTIMONY

23. Respondent presented expert testimony analyzing his treatment for Patient 1 from three witnesses. With one exception, noted below in Finding 35, these witnesses testified to substantially the same opinions.

a. Allan E. Sosin, M.D., is in private practice in southern California. Like respondent, Dr. Sosin emphasizes nutritional supplementation and complementary medical treatments in his practice.

b. Steven J. Bock, M.D., is in private practice in New York. Dr. Bock's practice emphasizes complementary and alternative treatments, and also diagnosis and treatment of Lyme disease.

c. Thomas James Grogan, M.D., is in private practice in southern California. Dr. Grogan is an orthopedic surgeon whose outpatient practice includes minor interventions in his office.

24. Complainant presented expert testimony about respondent's treatment for Patient 1 from Dinesh Sharma, M.D. Dr. Sharma is in private practice in central California, emphasizing physical medicine and rehabilitation.

Physical Examination

25. Dr. Sharma testified that the standard of care among physicians in California for treating a new patient with neck pain includes performing a complete physical examination of the patient's cervical spine. Such an examination includes looking carefully at the patient's head, neck, and shoulders; palpating the area to identify painful or swollen areas; conducting simple neurological tests to identify altered motor function or sensation in the head, neck, shoulders, or arms; examining range of motion; and examining blood supply. No other testifying physician expressly disagreed with this opinion, and it is persuasive.

26. Drs. Sosin, Bock, and Grogan each testified that he understood Bonnist to have performed a complete physical examination of Patient 1's cervical spine. The medical records in evidence, summarized above in Findings 13 through 16, did not support this understanding. Bonnist did not testify.

27. Drs. Sosin, Bock, and Grogan, and respondent, each testified that respondent could not have performed the injections described above in Findings 19 and 20 without having conducted a physical examination of Patient 1's spine to determine where to place the injections. This testimony is credible. Nevertheless, this testimony does not establish that respondent recorded any of his observations from such examinations, or that he ever personally performed any components of a complete cervical examination other than physically palpating part of Patient 1's cervical spine and some adjacent muscles.

28. In Dr. Sharma's opinion, respondent's failure to conduct a complete physical examination of Patient 1's cervical spine before offering Patient 1 treatment was a simple departure from the standard of care. Drs. Sosin, Bock, and Grogan each

testified that respondent could have met the standard of care by delegating the complete examination to Bonnist, and by following up himself only with a brief, focused examination of Patient 1's neck. In light of the matters stated in Findings 13 and 14, however, this opinion is irrelevant in this matter, because these experts' assumption that Bonnist conducted a complete physical examination of Patient 1's cervical spine is unfounded. Dr. Sharma's opinion is persuasive.

29. Dr. Sharma also testified that respondent's failure to document a complete physical examination of Patient 1's cervical spine at Patient 1's initial visit, and his failure to document any follow-up physical examination of Patient 1's spine at Patient 1's subsequent visits, were simple departures from the standard of care. These opinions are persuasive.

Informed Consent

30. Drs. Sharma, Sosin, Bock, and Grogan, and respondent, all testified that therapeutic "trigger point" injections such as those respondent performed for Patient 1 can be subcutaneous or intramuscular. Dr. Sosin and Dr. Grogan understood respondent's injections for Patient 1 to have been subcutaneous. Dr. Sharma understood them to have been intramuscular. Dr. Bock was not sure.

31. Dr. Sharma and Dr. Grogan both testified that they regularly perform trigger point injections similar to the injections respondent performed for Patient 1, but that they use an injection solution that contains a corticosteroid rather than ozone. Dr. Sosin and Dr. Bock use a prolozone compound similar to what respondent used for Patient 1. All testified that practitioners who administer trigger point injections involving ozone are less common than those who administer such injections using corticosteroids.

32. Dr. Sharma testified to his opinion that respondent had a professional responsibility to highlight for Patient 1 any special risks to Patient 1 from injections using prolozone rather than a corticosteroid. Drs. Sosin, Bock, and Grogan testified more persuasively that no such unusual risks exist. The evidence did not establish that respondent's inclusion of ozone in his subcutaneous injections for Patient 1 made those injections any riskier for Patient 1 than similar non-ozonated injections. At the same time, the evidence also did not establish that respondent's inclusion of ozone in his subcutaneous injections for Patient 1 made those injections any less risky for Patient 1 than similar non-ozonated injections.

33. Respondent's professional responsibility to inform Patient 1 about the injections' potential risks and benefits, and to secure his consent to these injections only after giving Patient 1 that information, was the same as it would have been if respondent had performed similar subcutaneous trigger point injections using a more conventional injection substance. According to the medical witnesses, the standard of care called for respondent to discuss foreseeable risks and benefits from subcutaneous trigger point injections with Patient 1; to secure his consent to this treatment only after giving Patient 1 material information; and to document that Patient 1 had consented to treatment after receiving adequate information.

34. Drs. Sharma, Sosin, Bock, and Grogan, and respondent, all agreed that trigger point injections generally are low-risk procedures. As risks worth disclosing to a patient, they identified bruising or bleeding from the skin puncture, and transient pain from the short-term effects of the injected substance on the surrounding tissue.

35. Drs. Sharma, Sosin, Bock, and Grogan also all agreed that trigger point injections are not complex or high-risk procedures for which the standard of care requires a physician to provide extensive information in writing to ensure adequately

informed patient consent. Dr. Sharma and Dr. Sosin testified, however, that respondent committed a simple departure from the standard of care by failing to document in Patient 1's records that he had told Patient 1 about the risks and benefits summarized in Findings 22 and 34. Dr. Bock and Dr. Grogan, by contrast, testified to their opinion that the generalized consent form described above in Findings 17 and 18 was adequate to document respondent's disclosure to Patient 1 of the potential risks and benefits from trigger point injections. Dr. Sharma's and Dr. Sosin's opinion is persuasive; Dr. Bock's and Dr. Grogan's is not.

Patient 2

36. Patient 2 consulted respondent for the first time in April 2017, when Patient 2 was 38 years old. He chose to consult respondent because he believed himself to have "chronic Lyme disease." Patient 2 had read an article about ozone treatments for chronic Lyme disease in a popular non-medical magazine, and then had found respondent by using the Internet to search for local providers who offered such therapies.

Relevant Medical History Before Care With Respondent

37. Patient 2 had experienced steadily declining health for several years before he consulted respondent. In April 2016, he visited a hospital emergency room because of extreme dizziness and weakness, and laboratory testing showed a high blood glucose concentration consistent with Type 2 diabetes mellitus. Patient 2 began taking medication for this condition, but later stopped taking medication and modified his diet in an effort to bring his blood glucose concentration under control.

38. Following his emergency room visit in April 2016, Patient 2 had a magnetic resonance imaging examination that showed him to have a "small pituitary

gland for age." In June 2016, based on this examination and on laboratory testing, Patient 2's treating physicians diagnosed Patient 2 with central hypogonadism and prescribed testosterone supplementation.

39. In May 2016, at a friend's recommendation, Patient 2 consulted William Mora, M.D., a physician in Sacramento who had treated Patient 2's friend for Lyme disease. On the basis of Patient 2's self-reported exposure and health history, a physical examination, and laboratory testing, Dr. Mora diagnosed Patient 2 with "a form of late Lyme disease." Dr. Mora prescribed doxycycline and hydroxychloroquine for Patient 2, and Patient 2 took these medications for at least 10 months.

40. Medical records in evidence regarding Patient 2's treatment with Dr. Mora show that Patient 2's last in-person appointment with Dr. Mora occurred on March 20, 2017. At this appointment, Dr. Mora recommended that Patient 2 continue taking doxycycline and hydroxychloroquine. At some time during 2017 Patient 2 stopped taking these medications, but the evidence did not establish precisely when or why.

INITIAL CONSULTATION AT RESPONDENT'S CLINIC

41. Patient 2 first contacted respondent's clinic by telephone on March 31, 2017. Before his first in-person visit, Patient 2 completed several questionnaires he had received by email from the clinic. He also requested that Dr. Mora and his treating physicians at Kaiser Permanente send records to respondent, but only "consult notes pertaining to Lyme; labs or testing for Lyme; xrays; MRI; CT."

42. Respondent's records do include visit records from Dr. Mora, as well as laboratory test results from Kaiser Permanente. Respondent's records do not indicate that respondent sought additional information from any other provider who recently

had treated Patient 2, or who currently was treating Patient 2. The records also do not show, and respondent did not testify, that he ever considered coordinating care for Patient 2 with any other physicians.

43. Patient 2 saw respondent as well as Devin Wilson, N.D., at his first appointment on April 13, 2017. Respondent's clinic records show that Patient 2 summarized Dr. Mora's diagnosis and treatment of Lyme disease. In addition, Patient 2 reported that he used supplemental testosterone because of hypogonadism, and that he had "hyperglycemia without diabetes." He described the problems that had motivated him to come to respondent's clinic as a recent "relapse" into illness, including "[f]atigue, electrical shocks throughout body, heat sensation all over body, numbness and tingling in hands, arms, legs, feet."

44. Wilson documented a partial physical examination of Patient 2. He noted that Patient 2's cranial nerves were "grossly intact," but did not document any neurological examination of Patient 2's torso or extremities. He also did not document any examination of Patient 2's abdomen or genitourinary system; any examination of Patient 2's heart, lungs, or circulation; or any testing of Patient 2's motor strength.

45. Respondent documented a conversation with Patient 2, but not any physical examination. His notes include no statement of his own diagnosis, and no differential diagnostic plan. The notes refer to a nutritional assessment and some laboratory testing that either respondent or Wilson would discuss with Patient 2 at the "next visit," but no such discussions ever occurred.

OZONE THERAPY

46. Patient 2's medical record includes two copies of a two-page document titled, "Informed Consent and Request for Care." It is very similar to the document

described above in Findings 17 and 18. Patient 2 had signed this document before his first office visit, but signed a second copy on April 13, 2017.

47. The document described in Finding 46 states the patient's understanding that the patient has the opportunity to ask questions about diagnosis and care. It also states that the patient potentially may receive any of a long list of diagnostic procedures or therapies, including "[i]ntravenous therapies and nutrients." As "[p]otential benefits" of any of these treatments, but without correlating any particular benefit to any treatment, the document lists "[r]estoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression." As "[p]otential risks" of any of these treatments, again without correlating any particular risk to any treatment, the document lists "[p]ain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms."

48. Respondent proposed to treat Patient 2 with nutritional supplements and intravenous ozone therapy. The intravenous ozone therapy involved withdrawing blood from Patient 2, mixing the blood with ozone, and returning the blood to Patient 2's body. Respondent advised one or two intravenous ozone therapy sessions per week, over about two months, at a total cost to Patient 2 of several thousand dollars.

49. Respondent provided literature and patient testimonials to Patient 2 about the intravenous ozone therapy he proposed. The evidence did not establish what medical information, if any, respondent gave to Patient 2 about the therapy's potential benefits, beyond the general statements described above in Finding 47 and

below in Finding 67. Patient 2 testified that he asked respondent questions about the treatment's risks, and that respondent did not identify any. Respondent testified credibly that he did tell Patient 2 that he might suffer pain or bruising at the venipuncture site.

50. Patient 2 had intravenous ozone therapy on April 13, 2017, and on several subsequent occasions (April 24, April 27, May 1, and May 5). On each occasion, a nurse administered the therapy, and documented the treatment session on a form and checklist respondent or his clinic staff had developed for this purpose. On April 24, April 27, May 1, and May 5, the nurse used a special device (the "Herrmann device") to administer the therapy. Respondent did not interact with Patient 2, except briefly and socially, during any of these treatments.

51. On May 17, 2017, the nurse administering intravenous ozone therapy to Patient 2 assembled the Herrmann device incorrectly, defeating a safety feature. Because of this error, the nurse introduced air into Patient 2's bloodstream instead of returning Patient 2's ozonated blood to his body. The air embolism caused Patient 2 to suffer a seizure and cardiac arrest.

52. Respondent led his staff members in resuscitating and stabilizing Patient 2. He also explained frankly to medical providers who treated Patient 2 in the California Pacific Medical Center emergency department and intensive care unit what had occurred to cause Patient 2's medical emergency.

53. Patient 2 spent about 10 days in hospitals immediately after the incident described in Finding 51, and several months thereafter receiving rehabilitative therapy. At the hearing, Patient 2 described his day-to-day physical health as "challenging."

EXPERT TESTIMONY

54. Complainant presented expert testimony about respondent's treatment for Patient 2 from George Melikian, M.D. Dr. Melikian is in private practice in southern California as a specialist in infectious disease diagnosis and treatment. Dr. Bock and Dr. Sosin testified for respondent regarding Patient 2.

Physical Examination, Diagnosis, and Documentation

55. Dr. Melikian criticized respondent for adopting Dr. Mora's diagnosis, and Patient 2's self-diagnosis, of "chronic Lyme disease." He stated that this diagnosis, as well as the process by which respondent reached it, were extreme departures from the standard of care.

a. According to Dr. Melikian, laboratory testing is important to determine whether a patient's health problems result from infection by the organisms that cause Lyme disease, or by related organisms. The laboratory testing results that Dr. Mora obtained for Patient 2, and that respondent reviewed, were not consistent in Dr. Melikian's opinion with Dr. Mora's conclusion that Patient 2 suffered an active Lyme or Lyme-like infection. As support for this opinion, Dr. Melikian cited diagnostic guidance regarding Lyme disease from the United States Centers for Disease Control (CDC). Dr. Melikian's further opinion is that respondent should not have relied on these results to conclude that current or former Lyme infection adequately explained the problems for which Patient 2 had consulted respondent.

b. Dr. Melikian also explained that even after active infection has resolved, some people who have had Lyme disease experience long-term health problems. He cited "cranial nerve palsies, peripheral neuropathies, and in rare cases, cerebellar ataxia" as examples, as well as "dermatological manifestations." In Dr.

Melikian's opinion, a careful physical examination (including a neurological examination, examination of the heart and lungs, and evaluation of motor strength and gait) is necessary to distinguish long-term consequences of Lyme disease from other phenomena that might cause similarly poor health but require different therapy.[4] Because of the matters stated above in Findings 44 and 45, Dr. Melikian concluded that respondent had not performed (or documented) such examination.

c. Dr. Melikian noted that because "one of the known complications of Lyme disease is secondary cardiac conduction abnormalities," a practitioner considering a diagnosis of "late Lyme disease" should perform an electrocardiogram (EKG) as part of the patient's examination.

56. Dr. Sosin also expressed skepticism about Dr. Mora's diagnosis of an active Lyme or Lyme-like infection for Patient 2, and about his use of long-term antibiotic therapy. He testified, however, that he believed intravenous ozone therapy to have been a reasonable treatment choice for Patient 2 regardless of what caused Patient 2's health complaints.

57. Dr. Bock testified to the opinion that laboratory testing is not especially reliable for diagnosing Lyme disease. In particular, Dr. Bock believes that a practitioner may meet the standard of care by diagnosing long-term Lyme disease consequences from clinical and exposure history and from current physical examination, without regard to serological laboratory testing that may be uninformative or ambiguous after

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[4] In light of the matters stated in Findings 37 and 38, Dr. Melikian identified Type 2 diabetes and central hypogonadism as two other diseases that, if un- or under-treated, might have explained Patient 2's malaise, neuropathy, and hot flushes.

acute infection has resolved. He testified further to his opinion that a physician who suspects long-term Lyme disease consequences should do neurological and cardiac evaluations on the patient, and that intravenous ozone therapy is often an appropriate and effective treatment for these patients.

58. Drs. Sosin and Bock testified that they understood Wilson to have performed a physical examination of Patient 2, and understood respondent to have relied on Wilson's report about that examination. The medical records in evidence, summarized above in Finding 44, showed Wilson to have performed only a cursory examination, however, and Wilson did not testify.

59. Dr. Bock testified that respondent did not depart from the standard of care by failing to obtain an EKG for Patient 2. He stated that he based this opinion in part on the fact that Patient 2 was not taking any medication that might cause heart rhythm abnormalities, and also on the fact that Patient 2 did not complain of any potentially heart-related symptoms. Neither of these bases is accurate. As stated in Finding 39, Patient 2 had been taking hydroxychloroquine for the previous 10 months, a medication Dr. Bock himself identified specifically in a declaration as having the potential to alter heart rhythm. And as stated in Finding 43, Patient 2 complained to respondent of chronic fatigue. In light of these inaccuracies, as well as of Dr. Bock's testimony (summarized in Finding 57) that a cardiac evaluation is appropriate for patients who may have late Lyme disease, Dr. Bock's opinion regarding respondent's omission of an EKG for Patient 2 is not persuasive.

60. Dr. Sosin also testified that respondent did not depart from the standard of care by failing to obtain an EKG for Patient 2. He based this opinion on his understanding that Patient 2 had a normal heart rate, had no symptoms suggesting heart dysfunction, and was relatively young. Dr. Sosin's failure to address the

possibility that long-term consequences from Lyme disease (or from treatment with hydroxychloroquine) may include heart rhythm abnormalities made his opinion less persuasive than Dr. Melikian's.

61. Respondent testified that he did not diagnose Patient 2 with active Lyme disease. Rather, he accepted Dr. Mora's diagnosis, and considered Patient 2 to be suffering long-term consequences from a former Lyme or Lyme-like infection. Respondent testified further that he gave careful consideration to explanations other than Lyme disease for Patient 2's symptoms, but this testimony is not credible in light of the matters stated in Findings 41 and 42. Instead, the more credible testimony by respondent is that he (like Dr. Bock and Dr. Sosin) considered intravenous ozone therapy appropriate for Patient 2 no matter what disease process was causing Patient 2's poor health. He viewed Patient 2 as having come to him for ozone treatment, not for diagnosis, and considered himself professionally responsible only for providing that treatment safely.[5]

62. Dr. Melikian's opinion that respondent erred in diagnosing Lyme disease in light of laboratory results that did not support this diagnosis is not persuasive, because respondent did not purport to diagnose Lyme disease.

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[5] As summarized in Findings 51 through 53, respondent's staff member failed to operate the Herrmann device safely. Complainant alleges, in reliance on the opinion described below in Finding 65, that respondent acted unprofessionally by failing to inform Patient 2 about the possibility that such an incident could occur. Complainant does not allege that the incident itself constituted or reflected any unprofessional conduct by respondent.

63. The remainder of Dr. Melikian's opinion is persuasive, however.

a. Respondent did not conduct, or rely reasonably on Wilson to have conducted, a physical examination that was adequate either to diagnose Patient 2's illness or to establish a baseline against which to compare Patient 2's condition after treatment.

b. If respondent truly did suspect Patient 2's condition to result from prior Lyme disease or related infection, respondent should have given special attention to a neurological examination, and should have performed an EKG.

c. Respondent did not document any baseline physical examination, and did not document follow-up physical examinations after Patient 2 had received intravenous ozone therapy.

d. Although (as summarized in Finding 45) respondent proposed to review further laboratory results and a nutritional assessment with Patient 2, he did not do so.

Respondent's decision to embark on an expensive, multi-month course of intravenous ozone therapy for Patient 2 without a clear understanding either of why Patient 2 was ill or of how respondent would evaluate the therapy's effectiveness was an extreme departure from the standard of care.

Informed Consent

64. As for Patient 1's trigger point injections, all medical witnesses agreed that the standard of care called for respondent to discuss foreseeable risks and benefits from intravenous ozone therapy with Patient 2; to secure his consent to this

treatment only after giving Patient 2 this material information; and to document that Patient 2 had consented to treatment after receiving adequate information.

65. Dr. Melikian testified that he believes respondent committed a simple departure from the standard of care by failing to document "a thorough discussion of risks associated with ozone therapy." In particular, Dr. Melikian faults respondent for having failed to document (or to conduct) any discussion with Patient 2 in which respondent disclosed the risk that intravenous ozone therapy with the Herrmann device could cause a potentially fatal air embolism.[6] He relied in part for this opinion on several articles describing known or suspected air embolisms resulting from ozone therapies, but none of these articles identifies air embolism as a risk of intravenous ozone therapy with the Herrmann device.

66. Drs. Bock and Sosin both have experience using the Herrmann device or a similar device for intravenous ozone therapy. They testified that the devices have safety mechanisms to prevent even minor gas bubbles from reaching the patient's bloodstream, and that air embolism is not a foreseeable complication from therapy with these devices. Their opinions on this issue were more persuasive than Dr. Melikian's. The evidence does not establish that respondent departed from the standard of care by failing to discuss, or to document having discussed, air embolism as a risk of intravenous ozone therapy.

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[6] Dr. Melikian did not identify any other specific risks that he believed respondent had omitted inappropriately from his disclosures to Patient 2, or any benefits that he believed respondent had misstated or overstated.

67. Dr. Bock, Dr. Sosin, and respondent all testified that the intravenous ozone therapy Patient 2 received carried the risks of transient fatigue, and of possible hematoma at the venipuncture site. They described this treatment's benefits in general terms, calling it "anti-inflammatory" and "anti-infective," and stating that it improves "mitochondrial function."

68. Despite the fact that the general consent form Patient 2 received (described above in Finding 46) included no information about specific risks or benefits from intravenous ozone therapy, Dr. Bock's opinion is that this document is adequate to memorialize the disclosures respondent made orally to Patient 2 (as described in Finding 49). This opinion is not persuasive.

69. Dr. Sosin, in contrast, testified to his opinion that respondent's failure to document any conversation with Patient 2 in which respondent specifically referenced any risks or benefits from intravenous ozone therapy was a simple departure from the standard of care.

70. Although the matters stated in Findings 64 through 69 do not establish respondent's failure to have secured Patient 2's adequately informed consent to intravenous ozone therapy, they do establish respondent's failure to have documented that informed consent in a manner conforming to the standard of care.

Additional Evidence

71. Respondent presented testimony from several character witnesses, and written references from several more. All expressed great affection and respect for respondent, praising his commitment to high-quality patient care and to charitable service.

72. Respondent has transitioned his practice to an electronic medical recordkeeping system. He testified credibly that this system facilitates more thorough and complete records, and better communication among clinic staff members. No examples were in evidence.

LEGAL CONCLUSIONS

1. The Board may discipline respondent's physician's and surgeon's certificate only upon clear and convincing proof, to a reasonable certainty, of the facts establishing cause for discipline. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The factual findings above rest on clear and convincing evidence.

2. Grossly negligent acts by a physician, which are acts involving extreme departures from the professional standard of care, are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (b).)

3. Repeated negligent acts by a physician, which are acts involving simple departures from the professional standard of care, are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (c).)

4. Acts demonstrating a physician's incompetence are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (d).)

5. A physician's failure to maintain adequate and accurate patient care records is unprofessional conduct. (Bus. & Prof. Code, § 2266.)

Causes for Discipline, Patient 1

6. The matters stated in Findings 25 through 28 establish negligence by respondent in recommending and providing prolozone injections without having performed a thorough examination of Patient 1's cervical spine. These multiple acts of negligence constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (c).

7. The matters stated in Findings 22 and 31 through 35 do not establish negligence by respondent in informing Patient 1 about subcutaneous trigger point prolozone injections or in securing his consent to treatment.

8. The matters stated in Findings 21 and 31 through 35 establish negligence by respondent in documenting the information he gave to Patient 1 about subcutaneous trigger point prolozone injections and about Patient 1's consent to receive them. In addition, the matters stated in Finding 29 establish negligence by respondent in failing to document either an initial thorough examination of Patient 1's cervical spine or any follow-up focused examination. These inadequate records constitute cause for discipline against respondent under Business and Professions Code section 2266.

Causes for Discipline, Patient 2

9. The matters stated in Findings 55 through 63 establish gross negligence by respondent, not in failing to follow CDC guidelines for diagnosing Lyme disease but in failing to perform a thorough, complete assessment of Patient 2 before beginning treatment. In addition, the matters stated in Findings 55 through 63 establish gross negligence by respondent in failing to perform a thorough physical examination of Patient 2, and in failing to include an EKG in his initial examination. These multiple acts

of gross negligence constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivisions (b) and (c).

10. The matters stated in Findings 49 and 64 through 70 do not establish negligence by respondent in informing Patient 2 about intravenous ozone therapy or in securing his consent to treatment.

11. The matters stated in Findings 64 through 70 do establish negligence by respondent in documenting the information he gave to Patient 2 about intravenous ozone therapy and about Patient 2's consent to receive this treatment. In addition, the matters stated in Findings 43 through 45 and 55 through 63 establish negligence by respondent in failing to document either an initial thorough physical examination of Patient 2 or any follow-up examination. These inadequate and inaccurate records constitute cause for discipline against respondent under Business and Professions Code section 2266.

12. The matters stated in Findings 55 through 70 do not establish incompetence constituting cause for discipline against respondent under Business and Professions Code section 2234, subdivision (d). Likewise, these matters do not establish inadequate or inaccurate procedure notes constituting cause for discipline against respondent under Business and Professions Code section 2266.

Disciplinary Considerations

13. Respondent has practiced medicine with skill and distinction for many years. Nevertheless, the matters stated in Findings 13 through 16 and 41 through 45 describe cursory, incomplete patient evaluations. Moreover, the matters stated in Findings 19 through 22, 30, and 46 through 49 describe minimally adequate efforts to explain specific potential medical benefits and risks of treatment, and little or no effort

to document such explanation or treatment. Respondent asked Patients 1 and 2, and asks the Board, simply to trust his expertise; but professional responsibility requires that respondent demonstrate (to his patients) and document (for himself, for his staff, and for other treatment providers) the factors justifying such trust.

14. With respect to Patient 2 in particular, respondent argues (as summarized in Finding 61) that Patient 2 came to respondent seeking intravenous ozone therapy, and that respondent fulfilled his professional responsibility to Patient 2 by determining that the treatment would not be unsafe and then providing it. Complementary medical treatments are permissible in California, and do not in and of themselves depart from the standard of care. (Bus. & Prof. Code, § 2234.1.) In this case, however, the matters stated in Findings 37 through 45 and 63 show that respondent neither examined and diagnosed Patient 2 carefully nor conferred with any other treatment providers about Patient 2. These omissions left Patient 2 at risk of substituting respondent's intravenous ozone therapy for other treatments that might also have addressed or even cured the diseases that caused his health complaints.

15. Although this matter involved only two patients, all evidence demonstrated that these patients' treatment (and respondent's documentation of it) was typical, not unusual. The unprofessional conduct described in Legal Conclusions 6, 8, 9, and 11 is not an isolated incident justifying only a public reprimand. A period of probation, on conditions including a requirement to take a course in medical record keeping, is appropriate to ensure improvements in respondent's practice and to protect public safety.

ORDER

Physician's and Surgeon's Certificate No. C 50117, issued to respondent Ahvie Herskowitz, M.D., is revoked. The revocation is stayed, however, and respondent is placed on probation for five years upon the following terms and conditions.

1. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the accusation, but prior to the effective date of this decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course,

or not later than 15 calendar days after the effective date of this decision, whichever is later.

2. Notification

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

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

3. Obey All Laws

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

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this decision.

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

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

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

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

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non practice. A Board ordered suspension of practice shall not be considered as a period of non practice.

In the event respondent's period of non practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws, Quarterly Declarations, and General Probation Requirements.

8. Completion of Probation

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

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed If an accusation, or petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in

determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

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

DATE:10/21/2021

Juliet E. Cox

JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings

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

In the First Amended Matter of the Accusation Against: **Ahvie Herskowitz, M.D.** **Anatara Group** **1700 California Street, Suite 520** **San Francisco, CA 94109** **Physician's and Surgeon's Certificate No. C 50117,** Respondent.	Case No. 800-2017-039339 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about June 5, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number C 50117 to Ahvie Herskowitz, 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 August 31, 2021, unless renewed.

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 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> (f) Approving undergraduate and graduate medical education programs.
>
> (g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).
>
> (h) Issuing licenses and certificates under the board's jurisdiction.
>
> (i) Administering the board's continuing medical education program.

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

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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which 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 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.

FACTUAL ALLEGATIONS

8. At all times relevant to this matter, Respondent was licensed and practicing medicine in San Francisco, California.

PATIENT P-1[1]

August 4, 2015 Visit

9. Patient P-1, a 71-year-old male, who has chronic neck pain from an industrial injury to his cervical spine, initially presented to Respondent's office on or about August 4, 2015 for alternative therapy and recommendations, including the possibility of joint injections and/or stem cell therapy. The patient chart notes for this date indicate that Patient P-1 had pain in his temple, bilaterally in neck and shoulders, both arms, and lower back. Respondent injected Patient P-1's

[1] The patient is designated in this document as Patient P-1 to protect the patient's privacy. Respondent knows the name of the patient and can confirm the patient's identity through discovery.

right paraspinal muscles at C6-7 and C7-T1,[2] with an anti-inflammatory mixture combined with ozone (hereinafter referred to as "prolozone therapy.") Respondent did not provide, or document, a physical examination of Patient P-1's cervical spine in Patient P-1's medical records. Respondent did not obtain informed consent from Patient P-1 regarding the nature, risks, and alternatives to the medical procedure and treatment that he performed on Patient P-1. Respondent did not prepare adequate and accurate procedure notes for this visit.

August 12, 2015 Visit

10. Patient P-1 returned to Respondent's office on or about August 12, 2015, where Patient P-1 again received prolozone therapy with injections to his paraspinal muscles at C4-C5, C5-C6, C6-C7, and C7-T1. Respondent did not provide, or document, a physical examination of Patient P-1's cervical spine in Patient P-1's medical records. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to the medical procedure and treatment performed on Patient P-1. Respondent did not prepare adequate and accurate procedure notes for this visit.

August 19, 2015 Visit

11. Patient P-1 returned to Respondent's office on or about August 19, 2015, where Patient P-1 again received prolozone therapy with injections to his paraspinal muscles at C4-C5, C5-C6, C6-C7, and T1. Respondent did not provide, or document, a physical examination of Patient P-1's cervical spine in Patient P-1's medical records. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to medical procedure and treatment. Respondent did not prepare adequate and accurate procedure notes for this visit.

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September 30, 2015 Visit

12. On or about August 31, 2015, Patient P-1 was referred to a pain management physician, who provided Patient P-1 with further care and recommended that Patient P-1 receive

[2] The spine is an intricate set of bones, muscles, nerves and discs. It is divided into five regions: cervical (neck bones); thoracic (in the chest); lumbar (low back); sacral (attached to the pelvis); and coccygeal (the tail bone). Each region has a number of vertebral bones. There are seven cervical vertebral bones referred as C1-C7. There are twelve thoracic bones referred as T1-T12).

platelet-rich plasma (PRP)[3] combined with stromal vascular fraction (SVF)[4] injections (hereinafter "stem cell therapy") for the cervical facet areas. Patient P-1 was scheduled for his stem cell procedure[5] on September 30, 2015. Respondent harvested two syringes of fat from Patient P-1. The removed fat was treated with a solution that included Collagenase.[6] The solution was then incubated for 30 minutes and then centrifuged for 4 minutes. The fat was removed and a washing formula of D5LR[7] was added. This was then centrifuged for 4 minutes and the process was repeated two more times for a total of three washings. Respondent harvested the stem cells into a 10 cc syringe and it was administered to Patient P-1 by the pain management physician.

13. The use of Collagenase for stem cell harvesting is not approved by the Food and Drug Administration (FDA). The use of ozone or prolozone therapy is not approved by the FDA.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts and/or Failure to Maintain Adequate and Accurate Records)

14. Respondent Ahvie Herskowitz, M.D. is subject to disciplinary action under section 2234 (c) of the Code (repeated negligent acts) and/or 2266 (inadequate records) in that Respondent engaged in the conduct described above, including but not limited to, the following:

a. Respondent recommended and provided ozone or prolozone therapy to Patient P-1 without first performing a physical examination of Patient P-1's cervical spine.

b. Respondent failed to obtain informed consent from Patient P-1 regarding the nature, risks and alternatives of ozone or prolozone therapy.

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[3] Platelet rich plasma (PRP) is produced by isolating plasma from blood and concentrating it. Plasma is a component of your blood that contains proteins that help blood to clot and support cell growth.

[4] Stromal vascular fraction (SVF) is a by-product of adipose harvesting of excess fatty tissue. This fraction contains a large number of stem cells, termed adipose derived stem cells.

[5] The stem cell procedure was conducted in two part; first, Respondent would harvest the stem cells from P-1, and then, P-1 would take the harvested stem cells to the pain management physician to be administered the same day.

[6] Collagenases are enzymes that break the peptide bonds in collagen.

[7] D5LR, is 5% Dextrose in lactated Ringer's solution, a fluid given intravenously to supply water, electrolytes that make it easier for a patient to absorb the fluid and sometimes nutrition to a person or animal in a hospital, home health care, or surgery situation. It can be used as a diluent or mixing solution.

c. Respondent failed to document discussion, if any, he had with Patient P-1 about the nature, risks and alternatives of ozone or prolozone therapy.

d. Respondent failed to thoroughly and accurately document physical examinations, if any, of Patient P-1's cervical spine.

e. Respondent used Collagenase for Patient P-1's stem cell harvesting which is not approved by the FDA.

f. Respondent used ozone or prolozone therapy which is not approved by the FDA.

PATIENT P-2[8]

April 13, 2017 Visit

15. Patient P-2, a 38-year-old male, who has a medical history of "relapsing Borrelia infection[9]," initially presented to Respondent's office on April 13, 2017, with a chief complaint of chronic Lyme disease.[10] Patient P-2 complained of muscle weakness, fatigue, extreme heat sensation, extreme electrical nerve sensation, and body alignment issues. Patient P-2 completed a Lyme disease questionnaire provided by Respondent in his diagnosis and treatment of Patient P-2. Respondent did not obtain a complete clinical history, exposure history, assessment and evaluation of symptoms and serologic/laboratory testing before he diagnosed and treated Patient P-2 for Lyme disease or tick-borne recurrent fever.[11] Respondent did not follow the two-step

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[8] The patient is designated in this document as Patient P-2 to protect the patient's privacy. Respondent knows the name of the patient and can confirm the patient's identity through discovery.

[9] Relapsing fever is a bacterial infection that can cause recurring bouts of fever, headache, muscle and joint aches, and nausea. There are three types of relapsing fever: tick-borne relapsing fever (TBRF), louse-borne relapsing fever (LBRF), and *Borrelia miyamotoi* disease (also called hard tick relapsing fever). The *Borrelia miyamotoi* disease occurs in the same places where Lyme disease is found and is transmitted by the blacklegged tick. https://www.cdc.gov/relapsing-fever/index.html Another physician, Dr. WM, made this diagnosis of Patient P-2 in August 2016.

[10] Lyme disease is a vector-borne disease caused largely by the bacterium *Borrelia burgdorferi* in the United States. It is transmitted to humans through the bite of infected blacklegged ticks. Typical symptoms include fever, headache, fatigue, and a skin rash. https://www.cdc.gov/lyme/index.html

[11] It is unclear whether Respondent diagnosed and treated Patient P-2 for Lyme disease and/or tick-borne recurrent fever as Respondent did not document his diagnosis in the patient's medical record.

process recommended by the Centers for Disease Control and Prevention (CDC) for diagnosing Lyme disease.[12] Respondent did not perform, or document, a physical examination of Patient P-2. Respondent did not obtain an electrocardiogram (EKG) to determine if Patient P-2 had other complications of Lyme disease.[13]

16. Respondent treated Patient P-2 with ozone therapy using the Hermann machine, a device which removes the patient's blood intravenously into an IV chamber, mixed with ozone[14], and the ozonated blood then returned to the patient. Respondent's plan for Patient P-2's ozone treatment consisted of increasing the number of passes of blood through the ozone chamber with each consecutive treatment session. Each pass consists of approximately 200 cc of blood through the ozone chamber. The goal is to reach up to 10 passes per treatment session. Patient P-2 completed his first ozone therapy session on April 13, 2017 with a single pass. The use of ozone therapy with the Hermann machine, an invasive therapeutic procedure, is not approved by the FDA.

17. Respondent did not obtain informed consent from Patient P-2 regarding the nature, risks, and alternatives to the ozone therapy treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

April 24, 2017 Visit

18. Patient P-2 returned to Respondent's office on April 24, 2017, where Patient P-2 again received ozone therapy using the Hermann machine. Patient P-2 received 3 passes of ozone therapy for this session. Respondent did not perform, or document, a physical examination of Patient P-2. Respondent did not obtain informed consent regarding the nature, risks, and

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[12] CDC recommends a two-step testing process for diagnosing Lyme disease, starting with a sensitive enzyme immunoassay (EIA) or immunofluorescense assay as a first test, followed by a Western immunoblot assay for specimens yielding positive or equivocal results. A negative result to the first test should be considered negative for Lyme disease and no further testing is indicated. https://www.cdc.gov/mmwr/preview/mmwrhtml/00038469.htm

[13] One of the known complications of Lyme disease is secondary cardiac conduction abnormalities such as atrioventricular heart block.

[14] Glutathione and n-acetyl-cysteine (NAC) are also added in this mixture. Respondent explained during his subject interview that these are antioxidants which are beneficial to the body.

alternatives to the ozone treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

April 27, 2017 Visit

19. Patient P-2 returned to Respondent's office on April 27, 2017, where Patient P-2 again received ozone therapy using the Hermann machine. Patient P-2 received 5 passes of ozone therapy for this session. Respondent did not perform, or document, a physical examination of Patient P-2. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to the ozone treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

May 1, 2017 Visit

20. Patient P-2 returned to Respondent's office on May 1, 2017, where Patient P-2 again received ozone therapy using the Hermann machine. Patient P-2 received 7 passes of ozone therapy for this session. Respondent did not perform, or document, a physical examination of Patient P-2. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to the ozone treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

May 5, 2017 Visit

21. Patient P-2 returned to Respondent's office on May 5, 2017, where Patient P-2 again received ozone therapy using the Hermann machine. Patient P-2 received 10 passes of ozone therapy for this session. Respondent did not perform, or document a physical examination of Patient P-2. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to the ozone treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

May 17, 2017 Visit

22. Patient P-2 returned to Respondent's office on May 17, 2017, where Patient P-2 again received ozone therapy using the Hermann machine. During this session, the nurse administering the ozone therapy noticed the flow rate was unusually slow during the re-infusion cycle, and attempted to adjust or replace the intravenous line, which caused the Hermann machine to blow

air into the intravenous line, resulting in an air embolus, aspiration, and cardiac arrest in Patient P-2. Respondent resuscitated Patient P-2 at Respondent's clinic. Patient P-2 was transferred by ambulance to the hospital and admitted to the Intensive Care Unit where he recovered.

23. Respondent did not perform, or document, a physical examination of Patient P-2. Respondent did not obtain informed consent regarding the nature, risks, and alternatives to the ozone treatment using the Hermann machine. Respondent did not prepare adequate and accurate procedure notes for this visit.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Incompetence and/or Failure to Maintain Adequate and Accurate Records)

24. Respondent Ahvie Herskowitz, M.D. is subject to disciplinary action under section 2234, subdivisions (b) (gross negligence), and/or (c) (repeated negligent acts); and/or (d) (incompetence); and/or 2266 (inadequate records) in that Respondent engaged in the conduct described above including, but not limited to, the following:

a. Respondent diagnosed and treated Patient P-2 for Lyme disease or tick-borne recurrent fever without obtaining a complete clinical history, exposure history, assessment and evaluation of symptoms and serologic/laboratory testing.

b. Respondent failed to follow the two-step process recommended by CDC for diagnosing Lyme disease.

c. Respondent did not perform a physical examination of Patient P-2.

d. Respondent failed to obtain an electrocardiogram (EKG) to determine if Patient P-2 had other complications of Lyme disease.

e. Respondent failed to obtain informed consent from Patient P-2 regarding the nature, risks and alternatives of ozone therapy using the Hermann machine.

f. Respondent used ozone therapy with the Hermann machine, an invasive therapeutic procedure that is not approved by the FDA.

g. Respondent failed to thoroughly and accurately document physical examinations, if any, of Patient P-2.

h. Respondent failed to prepare adequate and accurate procedure notes for Patient P-2's medical visits.

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 C 50117, issued to Ahvie Herskowitz, M.D.;

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

3. Ordering Ahvie Herskowitz, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: MAY 20 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2019201303