BEFORE THE
ACUPUNCTURE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA
In the Matter of the Accusation against:

DONALD C. HUGHES, L.Ac., Respondent

Acupuncturist License No. AC 16694

Case No. 1A-2017-242

OAH No. 2023081028

PROPOSED DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Acupuncture Board Department of Consumer Affairs as its Decision in the above-entitled matter.

This Decision shall become effective on May 16, 2024.

IT IS SO ORDERED this 16th day of April 2024.

By: Original Signature on File

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Administrative Law Judge Carl D. Corbin, State of California, Office of Administrative Hearings, heard this matter on February 14 and 15, 2024, in Oakland, California.

Supervising Deputy Attorney General Catherine B. Kim appeared on behalf of complainant Benjamin Bodea, Executive Officer of the Acupuncture Board, Department of Consumer Affairs, State of California.

Respondent Donald C. Hughes represented himself at hearing.

The record was held open for the parties to submit written closing arguments. The parties timely submitted written closing arguments. Complainant's closing argument was marked for identification as Exhibit 25. Respondent's closing argument

and cover letter were marked for identification as Exhibits J and K. Respondent also submitted a version of Business and Professions Code section 4961, which was operative from January 1, 2021, through December 31, 2023, which was marked as Exhibit I. Complainant objected to the submission of Exhibit I as not relevant and a violation of the order of the undersigned that closing briefs not include additional documentary evidence. Complainant's objection is noted; however, the undersigned will construe respondent's submission of Exhibit I as a request for official notice in accordance with Government Code section 11515. Respondent's request is granted, and official notice is taken of this version of Business and Professions Code section 4961, which was operative from January 1, 2021, through December 31, 2023.

The record closed and the matter was submitted for decision on March 1, 2024.

FACTUAL FINDINGS

Procedural Background

1. On June 12, 2015, the Board issued Acupuncturist License No. AC 16694 to respondent Donald C. Hughes. The license was in full force and effect at all times relevant to the Accusation, and will expire on July 31, 2024, unless renewed.

2. On June 30, 2022, complainant Benjamin Bodea, acting in his official capacity as Executive Officer of the Acupuncture Board, Department of Consumer Affairs (Board), issued an accusation against respondent. Complainant alleges that

respondent: threatened Patient 1[1] who submitted a complaint against him to the Board; failed to obtain proper informed consent from Patient 1 for the treatment he provided to her; failed to keep complete and accurate records regarding the treatment he provided Patient 1; failed to follow the infection control guidelines of the Board; failed to display his license in a noticeable location during Patient 1's treatment visits; failed to refund Patient 1 for treatments she paid for but did not receive; and provided treatment in at least three locations which were not properly registered with the Board. Complainant seeks the revocation of respondent's license and an order for respondent to pay the costs of investigation, including expert witness costs, and enforcement of this matter.

3. Respondent filed a notice of defense and this proceeding followed.

Patient 1

4. Patient 1 testified at hearing in a credible and sincere manner and her testimony was consistent with her complaint to the Board. While she could not fully recall everything from her 2017 acupuncture treatment sessions with respondent, she testified her contemporaneous complaint to the Board represented an accurate depiction of her interactions and concerns regarding respondent.

5. Patient 1 had various skin conditions and had received acupuncture treatment for several years prior to 2017 from acupuncturists other than respondent. Because of financial reasons, Patient 1 was no longer able to see her current

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[1] The complaining patient will be referenced in this decision as "Patient 1" in order to protect her privacy.

acupuncturist, so she sought an acupuncturist in the Arcata region who charged less for services. Through acquaintances, Patient 1 became aware of respondent and sought his acupuncture services. Patient 1 received acupuncture treatment from respondent six times from November 14, 2017, through December 5, 2017. On November 14 and 16, 2017, respondent provided acupuncture treatment to Patient 1 at Isis Osiris Healing Temple (Isis) located at 44 Sunnybrae Center in Arcata. Respondent rented (by the day or the hour) a treatment room at Isis to provide acupuncture treatment to Patient 1 and others. On November 14, 2017, respondent offered to provide Patient 1 with acupuncture treatment at his home at a discounted rate as he would not have to pay for a rental space at Isis. Patient 1 agreed to the offer. She went to respondent's home at 2557 Chestnut Place in Arcata and received acupuncture treatment on November 20, 27, 30, and December 5, 2017. The acupuncture treatment at respondent's home was performed on Patient 1 in respondent's bedroom on an acupuncture treatment table.

6. There is a dispute regarding whether respondent charged Patient 1 $30 or $40 per acupuncture treatment session. However, it is undisputed that Patient 1 paid respondent $200 on November 20, 2017, and there was a remaining balance of at least $40 that Patient 1 had paid respondent for future treatment that was not used. It is also undisputed that respondent never reimbursed Patient 1 the remaining unused balance.

7. Patient 1 testified that she had ongoing concerns regarding the acupuncture treatment she was receiving from respondent. These concerns included: he used the same linen sheet for the treatment table each session; she did not observe him wash his hands or use hand sanitizer prior to inserting needles in her; she did not observe any sharps disposable container during her treatment; and she did not hear

(she was facing down on the treatment table so she could not see) the "plinking" sounds of needles being discarded in a sharps container like she had during all of the acupuncture treatment sessions she had previously received from other acupuncturists. Patient 1 also testified to concerns regarding the conditions of respondent's home when she was there for acupuncture treatment, which included: the home did not seem clean, there were "always strange street kids lurking about in the other room," there was arguing in the other room, the home smelled of marijuana, and there was a "bong" in the living room.

8. Patient 1 testified that prior to her last acupuncture appointment on December 5, 2017, respondent sent her a series of texts that concerned and alarmed her regarding him being "kicked out" of a local bar and told not to return based on his behavior that included him laying "the smack down," and also that he had "booted this freeloading man baby" who was "devolving mentally" out of his home. Patient 1 still went to her December 5, 2017, acupuncture treatment appointment at respondent's home to get the "full story" from him.

9. Based on Patient 1's concerns set forth in Factual Findings 7 and 8, she discontinued receiving acupuncture treatment from respondent and stopped responding to his texts and his other attempts to contact her.

10. Patient 1 testified that she shared her concerns regarding respondent with her prior acupuncturist and that individual advised that she file a complaint with the Board.

11. During Patient 1's testimony at hearing, when she was asked if she completed new patient paperwork before initially receiving acupuncture treatment from respondent, she testified that she "might have," however she did not believe so

because her practice was to take a copy of anything she signed and she did not have any patient paperwork from respondent.

12. Approximately two weeks prior to the hearing in this matter, respondent produced a "consent to treatment and waiver" form with Patient 1's handwritten name, her handwritten initials in the signature box, and a handwritten date of November 14, 2017. At hearing Patient 1 persuasively testified that she did not sign this form and that the handwriting on the form was not hers. A comparison of the handwriting on the form and Patient 1's handwriting and signature on a declaration she completed on March 23, 2018, shows they are visibly different.

13. Patient 1 testified she did not recall seeing respondent's license posted at either Isis or respondent's home when she received acupuncture treatment from him. During cross-examination, Patient 1 admitted that she did not specifically look for respondent's license during her acupuncture treatment sessions at either Isis or respondent's home.

Complaint to the Board and Investigation

14. Patient 1 filed a complaint with the Board on December 12, 2017, regarding her concerns set forth in Factual Findings 7 through 10.

15. Department of Consumer Affairs, Division of Investigation (DOI) Investigator Alex Rudd began investigating Patient 1's complaint on March 1, 2018. Rudd interviewed witnesses, requested and reviewed documents from witnesses, and began drafting an investigation report. Rudd died and DOI Investigator Katherine

Taugher[2] was assigned to complete the investigation. Since 2008, Taugher has completed over 400 investigations for the DOI, which include investigations conducted regarding acupuncturists and other healing arts licensees. Taugher used the information from the investigation report partially completed by Rudd, interviewed witnesses (including respondent), collected and reviewed documents, and wrote a report dated October 17, 2018. Taugher testified at hearing in a credible manner consistent with the evidence and her testimony is given great weight.

16. Taugher testified at hearing that she did not recall receiving from respondent an informed consent for treatment document signed by Patient 1. Her report does not mention any such document. Taugher credibly testified that the form was not produced by respondent during the Board investigation and is not referenced in her report (which would have occurred if the form had been provided to Rudd). The evidence established Patient 1 did not sign the consent to treatment and waiver form; respondent appears to have fabricated the form and Patient 1's handwriting on the form.

17. On June 19, 2018, respondent received from the Board investigator a copy of the medical authorization signed by Patient 1. The next day, on June 20, 2018, respondent sent a series of texts to Patient 1 that made various assertions that included: "do you want to deny the world my medicine," "stand down," "[c]ontact me ASAP, otherwise I am filing a defamation of character suit against you on Friday," and "[t]alk to me before it gets ugly." Following receipt of the text messages from

[2] At time of the investigation her last name was Arnautovic.

respondent, Patient 1 contacted the Board investigator because she was distressed and scared.

18. Taugher spoke to respondent by telephone, exchanged email with him, and met him in person on August 8, 2018, at the Oakland Police Department, a location that was mutually agreed upon by Taugher and respondent. Taugher noted in her report that respondent had a "very strong body odor." At hearing, when questioned regarding why she included this information, she testified that other witnesses in her investigation had reported that respondent had a strong body order and she thought it was relevant to the cleanliness issue in Patient 1's complaint.

During the interview with Taugher:

- Respondent admitted that he moved to the Arcata area in the later part of 2017 through February 2018 when he provided acupuncture treatment to patients at Isis, his home on Chestnut Place, and at Core Pilates (at a location on 8th Street in Arcata).

- Respondent admitted that when he provided acupuncture treatment in a community setting at Isis he only changed the linens on the treatment table when there was visible blood and he did not change the linens after treating a patient with human immunodeficiency virus (HIV) before he treated his next patient.

- Respondent claimed that he only used acupuncture needles once before he disposed of the needles in a sharps container that he kept at his home. Later in the interview, he claimed he also carried a portable sharps container that he took with him when he provided acupuncture treatment. When questioned by Taugher during the interview about how

he disposed of the needles from the sharps container at his home, he provided inconsistent responses and claimed to dispose of the needles at a local hospital but he was unable to provide any further description of where exactly at the hospital the needles were disposed.

- Respondent claimed he washed his hands with soap and water before, and, usually, after providing acupuncture treatment to Patient 1.

- Respondent admitted he did not have time to take health histories from his patients when he provided acupuncture treatment in the community setting at Isis, although he did verbally ask if the patient had hepatitis or HIV and would record their answers only if they indicated a positive response.

- Respondent provided inconsistent responses regarding storage of his patients' records, stating initially he kept them in a storage unit located in Texas, but then he changed his response to his father's house in Texas.

19. On September 5, 2018, Taugher conducted a follow-up interview with respondent, during which he admitted that individuals at his home on Chestnut Place smoked marijuana but only did so in outside areas. Respondent also claimed that he always displayed his license on either the desk or wall so his patients could see it when he was performing acupuncture treatment.

20. Respondent's address of record with the Board for his place of practice from June 12, 2015, through at least February 5, 2018, was at 721 1/4 65th Street in Oakland. Respondent did not register with the Board any change in his place of practice during this period.

21. The Board investigation report states respondent admitted practicing acupuncture treatment at Isis, his home, and at Core Pilates located on 8th Street in Arcata. At hearing respondent denied providing acupuncture treatment at Core Pilates and credibly testified that he only taught martial arts at Core Pilates. At hearing, Taugher did not have a detailed recollection of this portion of her interview with respondent. There is no dispute that Patient 1 never received acupuncture at Core Pilates. In the absence of any additional proof regarding this issue, the evidence established respondent practiced acupuncture treatment during the relevant period at two locations: Isis and his home.

Testimony of M.C.[3]

22. M.C. testified at hearing in a straightforward manner consistent with telling the truth. M.C. testified that: she was the owner of Isis in 2017; she rented space at Isis on a temporary basis by the hour or by the day for health practitioners to perform services and none of the practitioners would use the same facility space on a permanent basis; for approximately six months in the later part of 2017 she rented a space at Isis for respondent to perform acupuncture treatment; she provided a treatment table at Isis but each practitioner brought their own treatment tools; practitioners were free to display their professional licenses while they rented a space at Isis; she did not make appointments or collect money for services on behalf of practitioners; she did not know if respondent registered Isis with the Board as a place of practice; she discontinued renting to respondent after hearing "negative things in the community" about him and after she spoke with the owner of the bar set forth in

[3] In order to protect her privacy, the witness will be referred to by her initials.

Factual Finding 8; and the only complaint she heard from people at Isis about respondent was a hygiene issue related to his strong body order.

23. M.C. did not testify that she provided linen sheets and a hamper to respondent when he was renting a treatment space at Isis.

Respondent's Contentions Regarding the Causes for Discipline

24. At hearing, respondent did not deny sending texts set forth in Factual Finding 17, but he testified his texts were made in an attempt at a peaceable resolution and that he did not intend to cause Patient 1 fear of physical or bodily harm. Respondent's testimony that his texts were not a threat or harassment was not credible.

25. Respondent testified that he provided the form, referenced in Factual Findings 12 and 16, to Patient 1 and had her sign it even though he did not verbally review or explain the information in the document with her. Respondent claims, without corroboration, that he provided the signed form to Investigator Rudd at some point during the Board's investigation. Respondent provided various reasons, none of which were credible, explaining the late production of the form shortly prior to the hearing in this matter.

26. During the Board investigation, respondent provided copies of his treatment records regarding Patient 1. The records included an approximate 20-line summary for each treatment session that included Patient 1's name, the date of treatment, and subjective, objective, and assessment information. The records were not signed or initialed by respondent.

Respondent testified at hearing to his belief that his record keeping regarding Patient 1 was adequate and that there was no legal requirement for him to obtain more detailed health histories from Patient 1 or other patients such as those he treated in community settings, as set forth in Factual Finding 18, to include not documenting a patient's negative response to having hepatitis or HIV.

27. During the Board investigation respondent claimed he only used single-use needles that were placed in a sharps container and disposed of at a local hospital. He also claimed he washed his hands with soap and water before and, sometimes, after performing treatment on Patient 1, and he changed and washed the treatment table linen sheet between Patient 1's treatment sessions. However, respondent did admit to only changing the linen sheet on the treatment table in the community setting when he saw visible blood and that he did not change the linen sheet between treating a patient with HIV and the next patient.

Respondent's testimony at hearing was generally consistent with the information he provided during the Board investigation regarding these issues. Except, he testified, without corroboration, that he "always" changed the linen sheet after seeing each patient in the community setting at Isis and that M.C. provided sheets for him along with a hamper to dispose of the used sheets.

28. Respondent in his Board investigation interview and in his testimony at hearing claimed he did display his Board-issued license at Isis and his home when he was providing acupuncture treatment to Patient 1, which he did by moving his license to each location when he was providing acupuncture treatment at that location.

29. Regarding the balance of funds paid by Patient 1 for services that she did not receive, set forth in Factual Finding 6, respondent contended he had no duty to

return the remaining balance of funds to Patient 1. On cross-examination when respondent was asked why he did not simply mail a check with the remaining balance to Patient 1's last known address, he testified that "it is not a requirement to send a check," "she did not return my phone calls," and "it is not my responsibility."

Expert Opinion

30. Alejandro Katz, O.M.D., L.Ac., was requested by the Board to review records and write an expert opinion report concerning whether respondent's actions deviated from the standard of care and violated one or more statutes or regulations. Dr. Katz received his doctorate degree in medicine in Argentina in 1976; he has been a licensed acupuncturist in California since 1984; and he is an Oriental Medical Doctor. He has approximately 10 years of experience teaching acupuncture. Dr. Katz is a past Director of the California Acupuncture Association and National Acupuncture Guild. He has testified as an industry expert for approximately 25 years on behalf of the Board and also in private litigation practice where he has testified about 40 percent of the time on behalf of the defense. Dr. Katz currently works full-time in private practice with four acupuncturists providing treatment to patients. Dr. Katz testified at hearing, he was credible and persuasive in all respects, and his testimony and expert report are given great weight.

THREATS OR HARASSMENT

31. Dr. Katz opined that the standard of care requires an acupuncturist who is the subject of a complaint to refrain from threatening or harassing the complaining individual.

32. As set forth in Factual Finding 17, on June 20, 2018, respondent sent a series of texts to Patient 1. Dr. Katz opined these texts constituted threats and harassment.

33. Dr. Katz opined that respondent's conduct in sending the text messages was not within the standard of care and represents an extreme departure from the standard of practice in the community and unprofessional conduct.

34. Clear and convincing evidence established that respondent's texts were threats or harassment against Patient 1 associated with the complaint she filed with the Board with the intention of having her withdraw her complaint and this constitutes unprofessional conduct and gross negligence.

INFORMED CONSENT

35. Dr. Katz opined that the standard of care for informed consent requires the acupuncturist to have a discussion regarding the proposed treatment and possible complications prior to any treatment being performed. After the discussion, but before any treatment occurs, an informed consent document should be signed and dated by the patient.

36. As set forth in Factual Finding 16, the evidence established Patient 1 did not sign any consent to treatment and waiver form and respondent appears to have fabricated the form and Patient 1's handwriting on the form.

37. Dr. Katz opined that respondent's conduct in failing to obtain written informed consent from Patient 1 prior to treating her was not within the standard of care and represents an extreme departure from the standard of practice in the community and unprofessional conduct.

38. The evidence established respondent failed to obtain written informed consent from Patient 1 prior to providing acupuncture treatment to her over the course of six sessions and this constitutes unprofessional conduct and gross negligence.

ADEQUATE TREATMENT NOTES

39. Dr. Katz opined the standard of care for record keeping requires an acupuncturist to keep complete, detailed, and accurate records for each patient who is provided treatment, including but not limited to date of treatment, type of treatments provided (such as examination with subjective complaints, objective findings and diagnosis, needle locations, use of cupping, massage, and herbal prescriptions), and progression or regression made as a result of the treatments. Dr. Katz opined the records need to be signed or initialed and dated by the acupuncturist. Dr. Katz also opined that an acupuncturist should document a patient's response, whether positive or negative, regarding questions such as whether the patient has hepatitis or HIV.

40. As set forth in Factual Finding 26, respondent provided the Board investigators copies of his treatment records regarding Patient 1.

41. Dr. Katz opined that respondent's records for Patient 1 did not include an adequate initial evaluation and did not document the progression or regression of her treated conditions, which was not within the standard of care. Dr. Katz also opined that respondent's failure to obtain adequate health histories from patients treated in community settings was not within the standard of care. Dr. Katz further opined that respondent's actions constituted an extreme departure from the standard of practice in the community and unprofessional conduct.

42. Clear and convincing evidence established that respondent failed to keep adequate records for Patient 1 and other patients he treated in the community setting and this constitutes unprofessional conduct and gross negligence.

INFECTION CONTROL GUIDELINES

43. Dr. Katz opined that the standard of care for sanitary and safe acupuncture treatment and compliance with infection control guidelines requires compliance with the Council of Colleges of Acupuncture and Oriental Medicine's Clean Needle Technique Manual, 7th Edition, which provides the standard by which acupuncturists prevent occupational exposure to healthcare associated pathogens and reduce the risk for some adverse events associated with acupuncture through use of the Clean Needle Technique (CNT). CNT components include: hand sanitation, establishing and maintaining a clean field, skin preparation, isolation of contaminated sharps, standard precautions, and the use of sterile single-use needles. In addition, if a linen sheet or table paper is used as a barrier on the treatment chair or table, these need to be changed for each patient.

44. Taugher and M.C. both testified at hearing that respondent had a strong body odor and complainant appears to suggest this is a violation of the standard of care for infection control guidelines of the Board. However, Dr. Katz did not directly opine on this specific issue and the evidence did not otherwise establish respondent's body odor was a violation of a standard of care or unprofessional conduct.

45. Dr. Katz opined that respondent's conduct in failing to wash his hands prior to treatment of Patient 1, respondent's use of the same linen sheet for each of the treatment sessions for Patient 1, the lack of a sharps container for disposal of the single-use needles used during treatment, and respondent's admission that he only

changed linens when treating patients (even those with HIV) in the community setting when there was visible blood, was not within the standard of care and represents an extreme departure from the standard of practice in the community and unprofessional conduct.

46. The evidence did not establish by clear and convincing proof that respondent violated infection control guidelines by failing to comply with the standard of care regarding the allegations that respondent did not wash his hands and did not use a sharps container to dispose of single-use treatment needles. Respondent's testimony was more convincing than Patient 1's testimony regarding his handwashing, disposal of needles, and washing the linen sheet between Patient 1's treatment sessions. In making his findings, Dr. Katz relied upon the observations of Patient 1 in the Board investigation report.

The evidence did establish by clear and convincing proof that respondent violated infection control guidelines by failing to comply with the standard of care for sanitary and safe acupuncture treatment by failing to change the linens between patients he treated in the community setting, except when he saw visible blood, including after a patient that had HIV, and this constitutes unprofessional conduct and gross negligence. Respondent's testimony was not credible that he changed the linen sheet between treating each patient in the community setting at Isis.

DISPLAY OF LICENSE

47. The version of Business and Professions Code[4] section 4961 in effect during the period of November 14, 2017, through December 5, 2017, when Patient 1 received acupuncture treatment from respondent, provided:

> (a) Every person who is now or hereafter licensed to practice acupuncture in this state shall register, on forms prescribed by the Acupuncture Board, his or her place of practice, or, if he or she has more than one place of practice, all of the places of practice. If the licensee has no place of practice, he or she shall notify the board of that fact. A person licensed by the board shall register within 30 days after the date of his or her licensure.
>
> (b) An acupuncturist licensee shall post his or her license in a conspicuous location in his or her place of practice at all times. If an acupuncturist has more than one place of practice, he or she shall obtain from the board a duplicate license for each additional location and post the duplicate license at each location.
>
> (c) Any licensee that changes the location of his or her place of practice shall register each change within 30 days of making that change. In the event a licensee fails to notify

[4] Statutory references are to the Business and Professions Code unless otherwise noted.

> the board of any change in the address of a place of practice within the time prescribed by this section, the board may deny renewal of licensure. An applicant for renewal of licensure shall specify in his or her application whether or not there has been a change in the location of his or her place of practice and, if so, the date of that change. The board may accept that statement as evidence of the change of address.[5]

48. In accordance with the relevant version of section 4961, subdivision (b), Dr. Katz opined the standard of care for displaying an acupuncturist license requires the posting of the license in a conspicuous location at all places of practice.

49. Based on the investigator's interview of Patient 1 in which she did not recall seeing respondent's license posted at either Isis or his home when she received acupuncture treatment from him, Dr. Katz opined that respondent's conduct was not within the standard of care and represented a simple departure from the standard of practice in the community.

50. The evidence did not establish by clear and convincing proof that respondent failed to display his Board-issued license in a noticeable location during all of Patient 1's acupuncture treatment sessions.

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[5] At hearing and in their closing briefs, the parties referred to other versions of section 4961 in effect at different periods of time; however, this version of section 4961 is the relevant version in this matter.

REFUND

51. Dr. Katz opined the standard of care for patient billing is for an acupuncturist to charge a fee to a patient after a service is provided by the acupuncturist unless the acupuncturist and patient make a different arrangement. Dr. Katz opined that if payment for services was made in advance, reimbursement to a patient for treatments not rendered is customary.

52. Dr. Katz opined that respondent's conduct in failing to return the remaining balance of funds to Patient 1, as set forth in Factual Finding 6, was not within the standard of care and represents a simple departure from the standard of practice in the community and unprofessional conduct.

53. Clear and convincing evidence established respondent failed to refund Patient 1 for acupuncture treatments she paid for but did not receive and this constitutes a simple departure from the standard of care and unprofessional conduct

REGISTERED TREATMENT LOCATIONS

54. Dr. Katz opined that the standard of care for performing acupuncture treatment requires the acupuncturist to register with the Board their place of practice, or, if they have more than one place of practice, all places of practice.

55. As set forth in Factual Finding 21, respondent provided acupuncture treatment at two locations: Isis and his home. As set forth in Factual Finding 20, neither of these places of practice was registered with the Board.

56. Dr. Katz opined that respondent's conduct in failing to register with the Board all his places of practice was not within the standard of care and represents a

simple departure from the standard of practice in the community and unprofessional conduct.

57. Clear and convincing evidence established respondent failed to register with the Board all his places of practice and this constitutes unprofessional conduct and repeated acts of negligence.

Respondent's Other Evidence

58. In respondent's testimony at hearing and in his arguments, he did not accept any responsibility for his conduct. He made multiple excuses for his conduct, some of which were not credible. He also placed blame and made unwarranted aspersions against Rudd, Taugher, and Patient 1. Respondent was remarkably dismissive of Dr. Katz's expert opinions in this matter making such assertions as "I do not think Dr. Katz understands what acupuncturists are like" and that Dr. Katz "seems to hate acupuncturists." Respondent generally asserted that because the relevant statutes do not specifically define a standard of care, there is no duty for him to comply with a standard of care such as those defined by Dr. Katz.

59. Respondent's apparent fabrication of a "consent to treatment and waiver" form, purportedly signed by Patient 1, and respondent's related testimony, as set forth in Factual Findings 16 and 25, greatly diminished his credibility.

60. Respondent testified he is a good acupuncturist, he likes helping people, and he would like to continue his practice as an acupuncturist. Respondent did not provide any evidence regarding his ability to pay for costs sought by complainant in this matter. Respondent also provided scant evidence of rehabilitation.

Costs

61. In connection with the investigation and expert witness costs for this matter, the Board has incurred costs in the amount of $12,692.44. In connection with the prosecution of this matter, the Board has incurred costs in the amount of $44,991.25. Complainant is requesting an award of a total of $57,683.69 for the costs of investigation, including expert witness costs, and enforcement of this matter. The request is supported by certifications and billing records that describe the tasks performed, the time spent on each task, and the method of calculating the cost in accordance with the requirements of California Code of Regulations, title 1, section 1042. The total costs of $57,683.69 sought by complainant are found to be reasonable.

LEGAL CONCLUSIONS

1. The standard of proof in this proceeding is clear and convincing evidence, and the burden of proof is on complainant. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence "requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind." (*Copp v. Paxton* (1996) 45 Cal.App.4th 829, 846, citations omitted.) If respondent contends mitigation or rehabilitation, it is his burden to prove those contentions by a preponderance of the evidence. (*Whetstone v. Board of Dental Examiners of Cal.* (1927) 87 Cal.App. 156, 164; Evid. Code, § 115.)

Causes for Discipline

2. The Board may discipline the license of a licensed acupuncturist for unprofessional conduct. (§ 4955.) The Board may also discipline the license of a

licensed acupuncturist for gross negligence, repeated negligent acts, or incompetence. (§ 4955.2.) An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

First Cause for Discipline: Threats or Harassment

3. The use of threats or harassment against any patient or licensee for providing evidence in a disciplinary action, other legal action, or in an investigation contemplating a disciplinary action or other legal action constitutes unprofessional conduct. (§ 4955, subd. (f).) Respondent sent threatening and harassing texts to Patient 1 related to the complaint she filed with the Board. (Factual Finding 34.) Cause for discipline against respondent's license exists under sections 4955, subdivision (f), and 4955.2, subdivision (a), for unprofessional conduct and gross negligence.

Second Cause for Discipline: Informed Consent

4. The Board may discipline the license of a licensed acupuncturist for failing to maintain adequate and accurate records relating to the provision of services to their patients, including documenting informed consent prior to treatment. (§ 4955.1, subd. (e); Cal. Code Regs., tit. 16, § 1399.453.) Respondent failed to obtain informed consent from Patient 1 prior to providing acupuncture treatment to her and he appears to have fabricated a written consent to treatment and waiver form regarding Patient 1. (Factual Findings 16, 38.) Cause for discipline against respondent's license exists under sections 4955, 4955.1, subdivision (e), and 4955.2, subdivision (a), and California Code of Regulations, title 16, section 1399.453, for unprofessional conduct and gross negligence.

Third Cause for Discipline: Adequate Treatment Notes

5. Respondent failed to keep adequate records on Patient 1 and patients he treated in the community setting. (Factual Finding 42.) Cause for discipline against respondent's license exists under sections 4955, 4955.1, subdivision (e), and 4955.2, subdivision (a), and California Code of Regulations, title 16, section 1399.453, for unprofessional conduct and gross negligence.

Fourth Cause for Discipline: Infection Control Guidelines

6. Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the Board constitutes unprofessional conduct. (§ 4955, subd. (e).) The Board has adopted a regulation codifying standards of practice for treatment procedures. (Cal. Code Regs., tit. 16, § 1399.451.) Respondent failed to comply with the infection control guidelines of the Board. (Factual Finding 46.) Cause for discipline against respondent's license exists under sections 4955, subdivision (e), and 4955.2, subdivision (a), and California Code of Regulations, title 16, section 1399.451, for unprofessional conduct and gross negligence.

Fifth Cause for Discipline: Display of License

7. As set forth in Factual Finding 47, the version of section 4961 in effect during the period of November 14, 2017, through December 5, 2017, required respondent to post his license at all times in a conspicuous location at all his places of practice. The evidence did not establish respondent violated this requirement and no cause for discipline exists on this basis. (Factual Finding 50.)

Sixth Cause for Discipline: Refund

8. Respondent failed to refund Patient 1 for treatment she paid for but did not receive. (Factual Finding 53.) Cause for discipline against respondent's license exists under sections 4955 and 4955.2, subdivision (b), for unprofessional conduct and repeated negligent acts.

Seventh Cause for Discipline: Register Treatment Locations

9. Respondent failed to register with the Board all his places of practice as required by the version of section 4961 in effect during the relevant period. (Factual Findings 57.) Cause for discipline against respondent's license exists under sections 4961 and 4955.2, subdivision (b), for unprofessional conduct and repeated negligent acts.

Determination of Discipline

10. The purpose of administrative proceedings regarding professional licenses is not to punish the applicant or licensee, but to protect the public. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 785-786; *Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 768.)

11. Protection of the public shall be the highest priority for the Acupuncture Board in exercising its licensing, regulatory, and disciplinary functions. (§ 4928.2.)

12. Cause for discipline having been established, as set forth in Legal Conclusions 3 through 6 and 8 through 9, the appropriate level of discipline to impose must be determined. The Board has adopted disciplinary guidelines, Department of Consumer Affairs, Acupuncture Board, Disciplinary Guidelines, 1996, (Guidelines) that shall be considered in reaching a decision on a disciplinary action. (Cal. Code Regs., tit.

16, § 1399.469.) For the causes of discipline established in this matter, the Guidelines recommend a maximum penalty of revocation and a minimum penalty of a stayed revocation with a period of probation with various terms and conditions.

13. Respondent's misconduct posed a risk of harm to patients and the public. He has not accepted responsibility for his misconduct. Respondent made excuses for his conduct, some of which were not credible. He placed blame on others, including Patient 1 and the DOI investigators. He also threatened and harassed Patient 1 when he became aware of her complaint to the Board. Fully acknowledging the wrongfulness of one's actions is an essential step toward rehabilitation (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) Respondent provided scant evidence of any rehabilitation.

Respondent's dismissal of Dr. Katz's expert opinions and respondent's refusal to acknowledge a standard of care, such as CNT, is quite troubling. However, most troubling is respondent's act of appearing to fabricate a written consent to treatment and waiver form regarding Patient 1 and his related testimony at hearing under penalty of perjury. "Intentional dishonesty . . . demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine." (*Windham v. Board of Medical Quality Assurance* (1980) 104 Cal.App.3d 461, 470.)

Protection of the public requires the outright revocation of respondent's license.

Costs

14. The Board is authorized to recover its reasonable costs of investigation and prosecution from a licensee found to have committed unprofessional conduct. (§ 4959.)

In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. None of these considerations support a reduction in cost recovery in this matter. The reasonable costs of $57,683.69, as set forth in Factual Finding 61, shall be imposed.

ORDER

1. Acupuncturist License No. AC 16694, issued to respondent Donald C. Hughes, is revoked.

2. Pursuant to Business and Professions Code section 4959, respondent Donald C. Hughes shall pay the Acupuncture Board the costs associated with its investigation and enforcement in the total amount of $57,683.69.

DATE: 03/26/2024

Carl D. Corbin

CARL D. CORBIN
Administrative Law Judge
Office of Administrative Hearings