

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

In the Matter of the Accusation)	
Against:)	
)	
)	
ALEXANDER GRINBERG, M.D.)	Case No. 03-2013-230317
)	
Physician's and Surgeon's)	
Certificate No. A56467)	
)	
Respondent)	
_____)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 15, 2016.

IT IS SO ORDERED: November 15, 2016.

MEDICAL BOARD OF CALIFORNIA



**Jamie Wright, J.D., Chair
Panel A**

1 KAMALA D. HARRIS
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 BRENDA P. REYES
Deputy Attorney General
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Attorneys for Complainant
7

8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 03-2013-230317

12 **ALEXANDER GRINBERG, M.D.**
13 **2320 Sutter Street, Suite 101**
San Francisco, CA 94115

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

14 **Physician's and Surgeon's Certificate**
15 **No. A 56467**

16 Respondent.

17
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
19 entitled proceedings that the following matters are true:

20 PARTIES

21 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
22 of California. She brought this action solely in her official capacity and is represented in this
23 matter by Kamala D. Harris, Attorney General of the State of California, by Brenda P. Reyes,
24 Deputy Attorney General.

25 2. Respondent Alexander Grinberg, M.D. ("Respondent") is represented in this
26 proceeding by attorney Stephen M. Boreman, Esq., whose address is: Slote, Links & Boreman,
27 LLP, One Embarcadero Center, Suite 400, San Francisco, CA 94111.

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1 3. On or about December 18, 1996, the Medical Board of California issued Physician's
2 and Surgeon's Certificate No. A 56467 to Respondent. The Physician's and Surgeon's Certificate
3 was in full force and effect at all times relevant to the charges brought in Accusation No. 03-
4 2013-230317, and will expire on December 31, 2016, unless renewed.

5 JURISDICTION

6 4. Accusation No. 03-2013-230317 was filed before the Medical Board of California
7 (Board), Department of Consumer Affairs, and is currently pending against Respondent. The
8 Accusation and all other statutorily required documents were properly served on Respondent on
9 January 6, 2015. Respondent timely filed his Notice of Defense contesting the Accusation. An
10 Amended Accusation (hereinafter "Accusation") was properly served on Respondent on February
11 23, 2015.

12 5. A copy of Accusation No. 03-2013-230317 is attached as Exhibit A and incorporated
13 herein by reference.

14 ADVISEMENT AND WAIVERS

15 6. Respondent has carefully read, fully discussed with counsel, and understands the
16 charges and allegations in Accusation No. 03-2013-230317. Respondent has also carefully read,
17 fully discussed with counsel, and understands the effects of this Stipulated Settlement and
18 Disciplinary Order.

19 7. Respondent is fully aware of his legal rights in this matter, including the right to a
20 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
21 the witnesses against him; the right to present evidence and to testify on his own behalf; the right
22 to the issuance of subpoenas to compel the attendance of witnesses and the production of
23 documents; the right to reconsideration and court review of an adverse decision; and all other
24 rights accorded by the California Administrative Procedure Act and other applicable laws.

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

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1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 03-2013-230317, if proven at a hearing, constitute cause for imposing discipline upon his
4 Physician's and Surgeon's Certificate.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
7 basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest
8 those charges.

9 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
10 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
11 Disciplinary Order below.

12 CONTINGENCY

13 12. This stipulation shall be subject to approval by the Medical Board of California.
14 Respondent understands and agrees that counsel for Complainant and the staff of the Board may
15 communicate directly with the Board regarding this stipulation and settlement, without notice to
16 or participation by Respondent or his counsel. By signing the stipulation, Respondent
17 understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation
18 prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation
19 as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or
20 effect, except for this paragraph, it shall be inadmissible in any legal action between the parties,
21 and the Board shall not be disqualified from further action by having considered this matter.

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

25 14. In consideration of the foregoing admissions and stipulations, the parties agree that
26 the Board may, without further notice or formal proceeding, issue and enter the following
27 Disciplinary Order:
28

1 **DISCIPLINARY ORDER**

2 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 56467 issued
3 to Respondent Alexander Grinberg, M.D. is revoked. However, the revocation is stayed and
4 Respondent is placed on probation for five (5) years on the following terms and conditions.

5 1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO
6 RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled
7 substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any
8 recommendation or approval which enables a patient or patient's primary caregiver to possess or
9 cultivate marijuana for the personal medical purposes of the patient within the meaning of Health
10 and Safety Code section 11362.5, during probation, showing all the following: 1) the name and
11 address of patient; 2) the date; 3) the character and quantity of controlled substances involved;
12 and 4) the indications and diagnosis for which the controlled substances were furnished.

13 Respondent shall keep these records in a separate file or ledger, in chronological order. All
14 records and any inventories of controlled substances shall be available for immediate inspection
15 and copying on the premises by the Board or its designee at all times during business hours and
16 shall be retained for the entire term of probation.

17 2. EDUCATION COURSE. Within 60 calendar days of the effective date of this
18 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
19 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
20 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
21 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
22 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
23 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
24 completion of each course, the Board or its designee may administer an examination to test
25 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
26 hours of CME of which 40 hours were in satisfaction of this condition.

27 3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
28 date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the

1 Prescribing Practices Course at the Physician Assessment and Clinical Education Program,
2 University of California, San Diego School of Medicine (Program), approved in advance by the
3 Board or its designee. Respondent shall provide the program with any information and documents
4 that the Program may deem pertinent. Respondent shall participate in and successfully complete
5 the classroom component of the course not later than six (6) months after Respondent's initial
6 enrollment. Respondent shall successfully complete any other component of the course within
7 one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense
8 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of
9 licensure.

10 A prescribing practices course taken after the acts that gave rise to the charges in the
11 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
12 or its designee, be accepted towards the fulfillment of this condition if the course would have
13 been approved by the Board or its designee had the course been taken after the effective date of
14 this Decision.

15 Respondent shall submit a certification of successful completion to the Board or its
16 designee not later than 15 calendar days after successfully completing the course, or not later than
17 15 calendar days after the effective date of the Decision, whichever is later.

18 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
19 date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to
20 the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education
21 Program, University of California, San Diego School of Medicine (Program), approved in
22 advance by the Board or its designee. Respondent shall provide the program with any
23 information and documents that the Program may deem pertinent. Respondent shall participate in
24 and successfully complete the classroom component of the course not later than six (6) months
25 after Respondent's initial enrollment. Respondent shall successfully complete any other
26 component of the course within one (1) year of enrollment. The medical record keeping course
27 shall be at Respondent's expense and shall be in addition to the Continuing Medical Education
28 (CME) requirements for renewal of licensure.

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

6 Respondent shall submit a certification of successful completion to the Board or its
7 designee not later than 15 calendar days after successfully completing the course, or not later than
8 15 calendar days after the effective date of the Decision, whichever is later.

9 5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this
10 Decision, Respondent shall submit to the Board or its designee for prior approval as a practice
11 monitor, the name and qualifications of one or more licensed physicians and surgeons whose
12 licenses are valid and in good standing, and who are preferably American Board of Medical
13 Specialties (ABMS) certified. A monitor shall have no prior or current business or personal
14 relationship with Respondent, or other relationship that could reasonably be expected to
15 compromise the ability of the monitor to render fair and unbiased reports to the Board, including
16 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree
17 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

18 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
19 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
20 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
21 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
22 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
23 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
24 signed statement for approval by the Board or its designee.

25 Within 60 calendar days of the effective date of this Decision, and continuing throughout
26 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
27 make all records available for immediate inspection and copying on the premises by the monitor
28 at all times during business hours and shall retain the records for the entire term of probation.

1 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
2 date of this Decision, Respondent shall receive a notification from the Board or its designee to
3 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
4 shall cease the practice of medicine until a monitor is approved to provide monitoring
5 responsibility.

6 The monitor(s) shall submit a quarterly written report to the Board or its designee which
7 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
8 are within the standards of practice of medicine, and whether Respondent is practicing medicine
9 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
10 that the monitor submits the quarterly written reports to the Board or its designee within 10
11 calendar days after the end of the preceding quarter.

12 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
13 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
14 name and qualifications of a replacement monitor who will be assuming that responsibility within
15 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
16 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
17 notification from the Board or its designee to cease the practice of medicine within three (3)
18 calendar days after being so notified Respondent shall cease the practice of medicine until a
19 replacement monitor is approved and assumes monitoring responsibility.

20 In lieu of a monitor, Respondent may participate in a professional enhancement program
21 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the
22 University of California, San Diego School of Medicine, that includes, at minimum, quarterly
23 chart review, semi-annual practice assessment, and semi-annual review of professional growth
24 and education. Respondent shall participate in the professional enhancement program at
25 Respondent's expense during the term of probation.

26 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
27 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
28 Chief Executive Officer at every hospital where privileges or membership are extended to

1 Respondent, at any other facility where Respondent engages in the practice of medicine,
2 including all physician and locum tenens registries or other similar agencies, and to the Chief
3 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
4 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
5 calendar days.

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

7 7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is
8 prohibited from supervising physician assistants.

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

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

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

17 10. GENERAL PROBATION REQUIREMENTS.

18 Compliance with Probation Unit

19 Respondent shall comply with the Board's probation unit and all terms and conditions of
20 this Decision.

21 Address Changes

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

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1 Place of Practice

2 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
3 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
4 facility.

5 License Renewal

6 Respondent shall maintain a current and renewed California physician's and surgeon's
7 license.

8 Travel or Residence Outside California

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

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

15 11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
16 available in person upon request for interviews either at Respondent's place of business or at the
17 probation unit office, with or without prior notice throughout the term of probation.

18 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
19 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
20 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
21 defined as any period of time Respondent is not practicing medicine in California as defined in
22 Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month
23 in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All
24 time spent in an intensive training program which has been approved by the Board or its designee
25 shall not be considered non-practice. Practicing medicine in another state of the United States or
26 Federal jurisdiction while on probation with the medical licensing authority of that state or
27 jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall
28 not be considered as a period of non-practice.

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

5 Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

7 Periods of non-practice will relieve Respondent of the responsibility to comply with the
8 probationary terms and conditions with the exception of this condition and the following terms
9 and conditions of probation: Obey All Laws; and General Probation Requirements.

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

14 14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
15 of probation is a violation of probation. If Respondent violates probation in any respect, the
16 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
17 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
18 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
19 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
20 the matter is final.

21 15. LICENSE SURRENDER. Following the effective date of this Decision, if
22 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
23 the terms and conditions of probation, Respondent may request to surrender his or her license.
24 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
25 determining whether or not to grant the request, or to take any other action deemed appropriate
26 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
27 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
28 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject


1 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
2 application shall be treated as a petition for reinstatement of a revoked certificate.

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

8 ACCEPTANCE


9 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
10 discussed it with my attorney, Stephen M. Boreman, Esq. I understand the stipulation and the
11 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
12 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
13 bound by the Decision and Order of the Medical Board of California.

14
15 DATED: 09/01/16


16 ALEXANDER GRINBERG, M.D.
17 Respondent

18 I have read and fully discussed with Respondent Alexander Grinberg, M.D. the terms and
19 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
20 I approve its form and content.

21
22 DATED: 9/1/16


23 STEPHEN M. BOREMAN, Esq.
24 Attorney for Respondent
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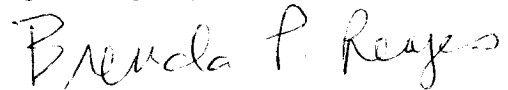
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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: *September 15, 2016*

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General



BRENDA P. REYES
Deputy Attorney General
Attorneys for Complainant

SF2014409231

Exhibit A

Accusation No. 03-2013-230317

1 KAMALA D. HARRIS
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2 JANE ZACK SIMON
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Attorneys for Complainant

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

11 In the Matter of the Amended Accusation
Against:

Case No. 03-2013-230317

12 **ALEXANDER GRINBERG, M.D.**
13 **2320 Sutter Street, Suite 101**
14 **San Francisco, CA 94115**

AMENDED ACCUSATION

15 **Physician's and Surgeon's Certificate**
16 **No. A 56467**

Respondent.

18 Complainant alleges:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
21 capacity as the Executive Director of the Medical Board of California, Department of Consumer
22 Affairs.

23 2. On or about December 18, 1996, the Medical Board of California issued Physician's
24 and Surgeon's Certificate Number A 56467 to Alexander Grinberg, M.D. (Respondent). The
25 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
26 charges brought herein and will expire on December 31, 2016, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board),¹ Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in relevant part:

"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."

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 in relevant part:

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

"(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.

¹ The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)

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

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

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

11 "(d) Incompetence."

12 7. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain
13 adequate and accurate records relating to the provision of services to their patients constitutes
14 unprofessional conduct.@

15 PERTINENT DRUGS

16 8. The following controlled substances and/or dangerous drugs are involved in this
17 proceeding:

18 A. **Adderall** is a trade name for **amphetamine** and **dextroamphetamine**, a central
19 nervous system stimulant. Amphetamine is a dangerous drug as defined in section 4022 of the
20 Code, a Schedule II controlled substance as defined by section 11055, subdivision (d) (1) of the
21 Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12 (d)
22 of Title 21 of the Code of Federal Regulations. Adderall is used in the treatment of Attention
23 Deficit Hyperactivity Disorder (ADHD). Like all amphetamines, it has a high potential for abuse.

24 B. **Ativan**, a trade name for **lorazepam**, is used for anxiety and sedation in the
25 management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety
26 associated with depressive symptoms. It is a Schedule IV controlled substance as defined by
27 section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined
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1 by Section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as
2 defined in Business and Professions Code section 4022.

3 C. **Cymbalta**, a trade name for **duloxetine**, is a selective serotonin and norepinephrine
4 reuptake inhibitor (SSNRI) antidepressant. Duloxetine affects chemicals in the brain that may
5 become unbalanced and cause depression. It is used to treat major depressive disorder in adults.
6 Duloxetine is a dangerous drug as defined in Business and Professions Code section 4022.

7 D. **Fentanyl** is an opioid analgesic. Fentanyl is a Schedule II controlled substance as
8 defined by section 11055 of the Health and Safety Code, and a Schedule II controlled substance as
9 defined by Section 1308.12 of Title 21 of the Code of Federal Regulations, and a dangerous drug
10 as defined in Business and Professions Code section 4022. Fentanyl's primary effects are
11 anesthesia and sedation. Fentanyl is a strong opioid medication and is indicated only for
12 treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means
13 and requires continuous opioid administration. Fentanyl presents a risk of serious or life-
14 threatening hypoventilation. When patients are receiving Fentanyl, the dosage of central nervous
15 system depressant drugs should be reduced at least 50%. Use of Fentanyl together with other
16 central nervous system depressants, including alcohol, can result in increased risk to the patient.

17 E. **Klonopin** is a trade name for **clonazepam**, an anticonvulsant of the benzodiazepine
18 class of drugs. Klonopin is used to treat seizure disorders or panic disorder. It produces central
19 nervous system depression and should be used with caution with other central nervous system
20 depressant drugs. Like other benzodiazepines, it can produce psychological and physical
21 dependence. Klonopin is a dangerous drug as defined in Business and Professions Code section
22 4022, a Schedule IV controlled substance as defined by section 11057 of the Health and Safety
23 Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the
24 Code of Federal Regulations.

25 F. **Lexapro**, a trade name for **escitalopram**, is an antidepressant belonging to a group of
26 drugs called selective serotonin reuptake inhibitors (SSRIs). Lexapro affects chemicals in the
27 brain that may become unbalanced and cause depression or anxiety. Lexapro is used to treat
28

1 anxiety in adults and major depressive disorder in adults and adolescents. Lexapro is a dangerous
2 drug as defined in Business and Professions Code section 4022.

3 G. **Prozac**, a trade name for **fluoxetine hydrochloride**, is an antidepressant used to treat
4 multiple conditions including major depressive disorder. Prozac is sometimes used together with
5 olanzapine (Zyprexa) to treat depression caused by bipolar disorder (manic depression). Prozac is
6 a dangerous drug as defined in Business and Professions Code section 4022.

7 H. **Ritalin** is a trade name for **methylphenidate hydrochloride**, a mild central nervous
8 system stimulant. Ritalin is used to treat attention deficit disorder (ADD) and attention deficit
9 and hyperactivity disorder (ADHD). It is a dangerous drug as defined in Business and Professions
10 Code section 4022 and a Schedule II controlled substance as defined in Health and Safety Code
11 section 11055.

12 I. **Suboxone** is a trade name for **buprenorphine HCl**, an opioid medicine similar to
13 morphine, codeine, and heroin. It targets the same places in the brain that opioids do. It relieves
14 drug cravings without inducing the same high as other opioid drugs. Buprenorphine can cause
15 side effects similar to other opioids and also can cause physical dependence. Buprenorphine can
16 help treat addiction to opioid drugs, including heroin and narcotic painkillers. It prevents or
17 reduces withdrawal symptoms caused by quitting these drugs. Suboxone is a dangerous drug as
18 defined in Business and Professions Code section 4022 and a Schedule V controlled substance as
19 defined by section 11058 (d) of the Health and Safety Code.

20 J. **Trazadone** is an antidepressant medicine used to treat major depressive disorder.
21 Trazadone is a dangerous drug as defined in Business and Professions Code section 4022.

22 K. **Valium** is a trade name for **diazepam**, a psychotropic drug used for the management
23 of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous
24 drug as defined in Business and Professions Code section 4022, and a Schedule IV controlled
25 substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV
26 controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal
27 Regulations. Diazepam can produce psychological and physical dependence and it should be
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1 prescribed with caution particularly to addiction-prone individuals (such as drug addicts and
2 alcoholics) because of the predisposition of such patients to habituation and dependence.

3 L. **Vicodin** is a trade name for a combination of **hydrocodone bitartrate and**
4 **acetaminophen** and is a semisynthetic narcotic analgesic. It is a Schedule III controlled
5 substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety
6 Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the
7 Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code
8 section 4022. Alcohol and other central nervous system depressants may produce an additive
9 central nervous system depression, when taken with this combination product, and should be
10 avoided. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety
11 agents, or other central nervous system depressants (including alcohol) concomitantly with
12 Vicodin may exhibit an additive central nervous system depression. The dose of one or both
13 agents should therefore be reduced.

14 **FIRST CAUSE FOR DISCIPLINE**

15 **(Re: Patient MM)**

16 **(Unprofessional Conduct/Gross Negligence/Repeated Negligent** 17 **Acts/Incompetence/Inadequate Records)**

18 9. Patient MM,² a 50-year-old woman, was first seen by Respondent in 2000 as an
19 inpatient at St. Luke's Hospital in San Francisco, where Respondent was working at the time as
20 an attendant psychiatrist. In or about 2003, MM began seeing Respondent in his private practice
21 in San Francisco. Patient MM remained a patient of Respondent's until approximately February
22 13, 2013, when Respondent terminated MM from his practice after she moved away.

23 10. Patient MM's chief complaints were chronic anxiety, panic attacks, and depression.
24 Patient MM also suffered from substance abuse, which included at various times opioid,
25 amphetamine, and/or cocaine abuse.

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27 ² Patient names are kept confidential to protect their right to privacy but will be identified
28 to Respondent in discovery.

1 11. On or about January 20, 2010, Respondent reported to the California Department of
2 Social Services that MM was unable to work due to fatigue, lack of focus, anxiety, and emotional
3 disturbance. Respondent's prescribed medications for MM at the time included Klonopin 2 mg.,
4 twice daily; Ativan 1-2 mg., 2-3 times daily, as needed; and, Prozac 20 mg. daily. Respondent
5 saw MM on March 19, 2010, at which time MM reported increased sadness and hopelessness.
6 MM reported that she was "clean," but that she had urges to use cocaine or "speed" to get some
7 relief. Respondent increased Klonopin 2 mg. to three times a day and he increased Prozac to 40
8 mg. daily.

9 12. MM saw Respondent on May 13, 2010 and reported frustration at the loss of effect of
10 Ativan and she reported using more than was prescribed. Respondent added diazepam (Valium)
11 10 mg. every 8 hours, as needed, to MM's prescribed medications.

12 13. On August 10, 2010, MM saw Respondent and reported a "few relapses of
13 amphetamine use." Portions of Respondent's progress note for this date are illegible. It appears
14 MM reported increased paranoia and that she took diazepam 4-5 times a day to relax and get
15 some sleep. As a result of the increased usage of diazepam, MM reported that she was out of the
16 medication. Respondent documented that he advised MM to get back into a rehabilitation
17 program. Respondent's records appear to document that he added Trazadone 100 mg. at bedtime
18 to MM's prescribed medications.

19 14. Respondent's records document that MM failed to appear for an appointment on
20 December 28, 2010. Respondent documented that he spoke with MM and that she reported
21 combining diazepam and Ativan to stop panic resulting from bad arguments with her boyfriend
22 and to suppress her cravings for cocaine. Respondent noted that he discussed the risks of
23 combining benzodiazepines with MM, "but as the combination works," he approved MM's
24 request that he continue prescribing both medications. Respondent's records document that on
25 January 18, 2011, Prozac was increased to 60 mg. daily.

26 15. Respondent saw MM on March 29, 2011, and noted that he had reviewed a
27 prescription profile for MM from her insurance company. Respondent documented that the
28 profile was consistent with MM's report of her use of benzodiazepines, i.e., that she runs out of

1 her medications usually 8-9 days early. MM reported that she had two one-day relapses on "MA"
2 (methamphetamine?). Respondent documented that he renewed MM's prescriptions for
3 Klonopin, diazepam, Ativan, Prozac, and Trazadone and that he encouraged MM to attend
4 Narcotics Anonymous and see a therapist.

5 16. On May 3, 2011, Respondent documented that MM was taking Vicodin, prescribed
6 by her primary care physician, for back pain. MM reported on this date that her boyfriend
7 occasionally "steals" a few of her diazepam and Vicodin.

8 17. On July 1, 2011, MM reported that she needed more Klonopin because of legal
9 problems. Respondent noted that MM was detained for shoplifting. MM also reported that she
10 was stressed by her boyfriend's behavior, which was not described in the record. Respondent
11 documented that he renewed MM's prescriptions.

12 18. Respondent's records document that on September 20, 2011, MM called to report that
13 she could not make her appointment because she was being hospitalized at U.C. San Francisco
14 Medical Center after having a stroke. MM reported that she had used cocaine for a few days prior
15 to the stroke. On October 13, 2011, Respondent noted that MM had been discharged from the
16 hospital two weeks prior and that she had mild to moderate left side residual weakness.

17 19. On November 26, 2011, MM was admitted to U.C. San Francisco Medical Center due
18 to somnolence following over-ingestion of psychiatric medications. MM's hospital course
19 included discovery of bilateral pulmonary emboli. During MM's hospitalization all psychiatric
20 medications were discontinued with the exception of Klonopin, which was reduced to 0.5 mg.
21 twice a day, and Prozac, which was reduced to 10 mg. daily. MM was discharged from the
22 hospital on December 2, 2011. The hospital record documents that at the time of discharge MM
23 was not requiring additional PRN doses. The Discharge Summary notes that MM was to continue
24 on Klonopin 0.5 mg. twice daily either until long-term maintenance became effective for anxiety
25 symptoms or until MM could be weaned off of benzodiazepines completely. The Discharge
26 Summary documents that the importance of a lock-box to secure MM's prescribed medications
27 was discussed with MM and her daughters and that MM's daughters agreed to administer MM's
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1 prescribed medications to her. MM's daughters were also advised to accompany MM to her
2 appointment with Respondent to set new goals and expectations.

3 20. Respondent's records document that on December 27, 2011, MM called and
4 complained that Klonopin 0.5 mg. was inadequate and that she was experiencing increased
5 anxiety. MM also reported that she could not be dependent on her daughter to dispense her
6 medications when she needs them because her daughter is busy and unavailable. Respondent
7 increased Klonopin to 1 mg. twice a day and Prozac to 20 mg. daily. On January 13, 2012,
8 Respondent saw MM and prescribed Klonopin, Prozac, and Ativan 2 mg. every 8 hours, as
9 needed. On March 3, 2012, Respondent increased MM's Prozac dose to 40 mg. daily.

10 21. Respondent's records document that on April 17, 2012, he was notified that MM was
11 being discharged from San Francisco General Hospital to Shrader House, a short-term crisis
12 residential program for treatment of acute symptoms of mental illness. Respondent noted that
13 MM's prescribed medications at this time included Trazadone 50-100 mg. at bedtime, as needed.

14 22. Respondent's records document that on September 14, 2012, MM called and
15 requested that Respondent fax a prescription for her medications to a new pharmacy because she
16 had moved to Antioch, CA. Patient MM reported that the move was temporary. Respondent
17 documented that he faxed a prescription to the pharmacy for Klonopin 2 mg., twice daily; Prozac
18 40 mg. daily; and, Trazadone 50-100 mg. at bedtime.

19 23. Respondent's records document that on October 9, 2012, MM called and reported
20 increased anxiety and frequency of panic attacks. Respondent prescribed diazepam 10 mg. every
21 12 hours, as needed.

22 24. Respondent's records document that on October 25, 2012, MM failed to appear for
23 her scheduled appointment. Respondent spoke by telephone with MM later that day. MM
24 reported that she was thinking of staying in Antioch for good. Respondent agreed to provide MM
25 with two more refills of her medications to continue her treatment until she could arrange care
26 with another provider. Respondent's records document that he continued to get telephone calls
27 from the patient over the next several months requesting that he refill her medications. On
28 February 13, 2013, Respondent documented that he terminated the physician-patient relationship.

1 25. Respondent's records document that MM repeatedly failed to appear for scheduled
2 appointments. Respondent's records and pharmacy prescribing records document that
3 Respondent routinely provided MM with early refills of her prescribed medications.
4 Respondent's records routinely fail to document the quantity of the medications prescribed.
5 Respondent's progress notes are handwritten. Several of the notes contain handwriting that is
6 illegible.

7 26. Respondent is guilty of unprofessional conduct and subject to disciplinary action
8 under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that
9 Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was
10 incompetent in the practice of medicine in his care and treatment of Patient MM, including but
11 not limited to the following:

12 A. Patient MM was not an appropriate candidate for long-term use of
13 benzodiazepine medications or for "as needed" dosing because of her known active substance
14 abuse. The standard of care in treating a dual diagnosis patient in the office setting is to treat the
15 substance abuse first and taper and discontinue addicting medications. Respondent
16 simultaneously prescribed two or three benzodiazepine medications, in high doses, and he ordered
17 some of the medications to be taken on an "as needed" basis so that MM could use her own
18 judgment about when to use the medications for symptom relief.

19 B. Respondent failed to manage, and/or failed to document management of Patient
20 MM's psychiatric conditions and medication use, including but not limited to, laboratory testing
21 to monitor compliance with prescribed medications; response to treatment; side effects to
22 medications; sustained trials off benzodiazepine medications; and, medical necessity for the
23 continued prescribing of medications.

24 C. Respondent failed to monitor the patient's medication use for early refills.

25 D. Respondent failed to refer Patient MM to a substance abuse specialist.

26 27. Respondent is guilty of unprofessional conduct and subject to disciplinary action
27 under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate
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1 records related to his care and treatment of Patient MM, including but not limited to the
2 following:

3 A. Respondent failed to document periodic review of the patient's treatment plan
4 and medications, such as the patient's compliance with prescribed medications; response to
5 treatment; and, any side effects to medications.

6 B. Respondent failed to document in the patient record the quantity of prescribed
7 medications.

8 C. Significant portions of Respondent's progress notes are illegible.

9 **SECOND CAUSE FOR DISCIPLINE**

10 **(Re: Patient MT)**

11 **(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/
12 Incompetence/Inadequate Records)**

13 28. Patient MT, a 52-year-old woman, was a patient of Respondent's from 1999 to
14 approximately 2006. Patient MT returned to see Respondent on April 4, 2011. In an Initial
15 Psychiatric Evaluation of the same date, Respondent noted that MT has a history of depression,
16 anxiety disorder with panic attacks, and attention deficit disorder (ADD). She had been treated in
17 the past with antidepressants from the SSRI group, and with Wellbutrin and Effexor; with mood
18 stabilizers such as gabapentin and Topamax; and, with anti-anxiety medications, such as
19 clonazepam and lorazepam. Respondent noted that MT achieved the best results treating her
20 ADD with Adderall. MT's history also included morbid obesity and bariatric surgery which was
21 done in 2004. The surgery helped MT lose a significant amount of weight, but left her with many
22 gastroenterological complications, including severe abdominal pain.

23 29. On April 4, 2011, Respondent performed a mental status examination of MT and
24 noted that her mood was moderately depressed and that she demonstrated moderate-to-severe
25 deficits of attention and concentration. Respondent's diagnoses were depressive disorder,
26 generalized anxiety disorder, and ADD. Respondent prescribed Lexapro 10 mg. daily, Klonopin
27 0.5 mg. once a day, Topamax (an anticonvulsant) 25 mg. twice daily, and Adderall 10 mg. twice
28 daily.

1 30. Respondent's care of Patient MT was reviewed for the time period April 2011
2 through approximately April 2014. Respondent's records contain 26 progress notes for this time
3 period documenting doctor-patient interactions. Portions of Respondent's progress notes are
4 illegible. The records, nevertheless, document that in at least twelve of the documented
5 interactions Patient MT did not physically appear for an appointment.

6 31. Respondent's records and pharmacy prescribing records for Patient MT indicate that
7 Respondent regularly prescribed MT clonazepam 0.5 mg. three times daily for treatment of her
8 anxiety and panic attacks, and Adderall 20-60 mg. daily to treat her ADD and lack of energy.
9 Pharmacy prescribing records for Patient MT indicate that during the period Respondent's care
10 was reviewed, MT received monthly prescriptions for lorazepam 1 mg., #60, prescribed by
11 another physician. Beginning in at least December 2011, through April 2014, MT also received
12 monthly prescriptions for liquid Vicodin 7.5-325/15 ml, #2365 ml., also prescribed by another
13 physician. At his Medical Board interview on May 13, 2014, Respondent reported that he was
14 aware that MT was receiving prescriptions for lorazepam and Vicodin from another physician.

15 32. Respondent is guilty of unprofessional conduct and subject to disciplinary action
16 under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that
17 Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was
18 incompetent in the practice of medicine in his care and treatment of Patient MT, including but not
19 limited to the following:

20 A. Respondent prescribed clonazepam and Adderall to Patient MT, while knowing
21 she was receiving prescriptions for lorazepam and Vicodin from another physician, thereby
22 placing Patient MT at higher risk of toxicity, respiratory depression, addiction, and possibly other
23 complications.

24 B. Respondent failed to consult with and/or failed to coordinate care of Patient MT
25 with her other prescribing physicians in order to avoid duplication and/or adverse drug
26 interactions.

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1 C. Respondent failed to have regular face-to-face follow up visits with Patient MT
2 and he failed to document periodic review of the patient's treatment plan and medications in order
3 to rectify the poly-pharmacy and multiple prescriber issues.

4 33. Respondent is guilty of unprofessional conduct and subject to disciplinary action
5 under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate
6 records related to his care and treatment of Patient MT, including but not limited to the following:

7 A. Respondent failed to document in the patient record the quantity of prescribed
8 medications.

9 B. Significant portions of Respondent's progress notes are illegible.

10 **THIRD CAUSE FOR DISCIPLINE**

11 **(Re: Patient AV)**

12 **(Unprofessional Conduct/Gross Negligence/Inadequate Records)**

13 34. Patient AV, a 46-year-old man, was first seen by Respondent as an outpatient during
14 the time Respondent worked at St. Luke's Hospital. Patient AV served time in jail for domestic
15 violence and returned to see Respondent on February 18, 2007. In an Initial Psychiatric
16 Evaluation Report of the same date, Respondent noted that AV suffers from generalized anxiety
17 disorder and panic attacks. AV's medical history includes morbid obesity and borderline
18 hypertension. AV reported a history of experimenting with amphetamine and cocaine, but
19 discontinuing them due to panic attacks and severe anxiety.

20 35. Patient AV reported that while in jail he was involved in gang activity. He reported
21 that now that he was out of jail he was afraid to leave his home, even for doctor visits, for fear of
22 being attacked or killed by gang members. AV reported SSRI antidepressants and Buspar were
23 ineffective in treating his anxiety and panic attacks. He reported being treated in the past with
24 clonazepam 2 mg., three times daily, and Valium 10 mg., every 8 hours, as needed, for panic
25 attacks. Respondent noted that AV had a high tolerance to benzodiazepines due to his morbid
26 obesity.

27 36. Patient AV's complaints included panic attacks up to four times a day, extreme
28 anxiousness, fearfulness, and fear of eminent death. The patient reported eating to comfort

1 himself. AV reported that he could not go to therapy because he could not be out on the street for
2 fear of being killed and because of the difficulty ambulating due to his significant weight.

3 Respondent documented a mental status examination and he diagnosed generalized anxiety
4 disorder with panic attacks and possible post traumatic stress disorder. Respondent prescribed
5 Klonopin 2 mg., 3 times daily, and Valium 10 mg., every 8 hours, as needed, for panic.

6 Respondent noted that AV consented to communicate with Respondent by telephone every 2-3
7 months and to see Respondent "when he can," i.e., "when transportation is available and [AV]
8 does not have to use public transportation."

9 37. Respondent's care of Patient AV was reviewed for the time period October 2010
10 through approximately April 2014. Respondent's records contain 13 progress notes for this time
11 period documenting doctor-patient interactions, at least six of which were telephone calls with the
12 patient. The records indicate that Respondent saw Patient AV one time during 2011, as many as
13 three times during 2012, and one time during 2013. Respondent's records and pharmacy
14 prescribing records for Patient AV indicate that from August 2012 through January 2014, Patient
15 AV received monthly prescriptions from Respondent for Klonopin 2 mg., #120, and Valium 10
16 mg., #120.

17 38. On February 22, 2014, Patient AV saw Respondent and reported that for at least the
18 last two months he had filled his prescriptions at different pharmacies in order to stock up. AV
19 explained that because he was living alone and with his anxiety increasing he was afraid he would
20 not be able to get out to get his medications when he needed them. AV asked Respondent to
21 provide him with prescriptions for two months worth of medications to avoid this problem.

22 Respondent agreed to provide AV with prescriptions for two months of medications "to minimize
23 his need to go out." Pharmacy prescribing records indicate that on February 22, 2014,
24 Respondent prescribed Klonopin 2 mg., #240, and Valium 10 mg., #240.

25 39. Respondent is guilty of unprofessional conduct and subject to disciplinary action
26 under section 2234, and/or 2234 (b) of the Code in that Respondent was grossly negligent in the
27 practice of medicine in his care and treatment of Patient AV, including but not limited to the
28 following:

1 A. Respondent prescribed two benzodiazepine medications, long term, and in high
2 doses without documentation of medical indication for the ongoing prescribing.

3 B. Over the course of his treatment with Respondent, Patient AV essentially
4 became housebound due to fear and he developed a tolerance for and dependency on the
5 temporary relief from benzodiazepine medications. When his psychiatric condition did not show
6 improvement, Respondent failed to consider alternative treatments and/or medication
7 adjustments.

8 40. Respondent is guilty of unprofessional conduct and subject to disciplinary action
9 under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate
10 records related to his care and treatment of Patient AV, including but not limited to the following:

11 A. Respondent failed to document in the patient record the quantity of prescribed
12 medications.

13 B. Portions of Respondent's progress notes are illegible.

14 **FOURTH CAUSE FOR DISCIPLINE**

15 **(Re: Patient DK)**

16 **(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/ 17 Incompetence/Inadequate Records)**

18 41. Respondent first saw Patient DK, a 54-year-old man, on January 20, 2007, upon
19 referral after the patient was hospitalized for 72-hours because of "SI" (suicidal ideation?). Most
20 of Respondent's initial progress note is illegible. It appears that the patient had a history of mood
21 disorder, depressive disorder, generalized anxiety with panic attacks, and ADD. DK appears to
22 have reported a history of self-medicating with cocaine. At his Medical Board interview on May
23 13, 2014, Respondent reported that DK also had multiple medical comorbidities and orthopedic
24 problems. Respondent started DK on Cymbalta 40 mg. (frequency illegible). On October 19,
25 2007, Respondent saw Patient DK and prescribed Ritalin 10 mg., three times daily.

26 42. Respondent's progress notes for Patient DK are frequently very brief in detail and
27 illegible. Respondent's progress notes and pharmacy prescribing records indicate that at least by
28 January 2011, through February 2014, Patient DK received monthly prescriptions from

1 Respondent for Ritalin 20 mg., 3-4 times a day; Ativan 1-2 mg., 2-3 times a day; Valium 10 mg.,
2 up to 8 tablets a day; and, Klonopin 2 mg., up to 4 times a day. Pharmacy prescribing records
3 indicate that from January 2011 through at least July 2012, Patient DK received prescriptions for
4 Fentanyl 50-75 mcg./hr., one patch every 48 hrs., from another physician. Patient DK also
5 received from February 2013 through March 2014, prescriptions for Suboxone 8 mg./2 mg.
6 prescribed by another physician. At his Medical Board interview, Respondent stated that he was
7 aware that Patient DK received prescriptions for Fentanyl and Suboxone from another physician.
8 Respondent's records do not document that he consulted with nor coordinated care and
9 medication prescribing with Patient DK's other physicians.

10 43. Respondent is guilty of unprofessional conduct and subject to disciplinary action
11 under section 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that
12 Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was
13 incompetent in the practice of medicine in his care and treatment of Patient DK, including but not
14 limited to the following:

15 A. Respondent prescribed Ritalin, Ativan, Valium, and Klonopin to Patient DK,
16 while knowing he was receiving prescriptions for Fentanyl and Suboxone from another physician,
17 thereby placing Patient DK at higher risk of toxicity, respiratory depression, addiction, and
18 possibly other complications.

19 B. Respondent failed to consult with and/or failed to coordinate care and
20 medication prescribing with Patient DK's other prescribing physicians.

21 44. Respondent is guilty of unprofessional conduct and subject to disciplinary action
22 under sections 2234 and/or 2266 of the Code in that he failed to keep adequate and accurate
23 records related to his care and treatment of Patient DK, including but not limited to the following:

24 A. Respondent failed to document in the patient record the quantity of prescribed
25 medications.

26 B. Significant portions of Respondent's progress notes are illegible.

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1 **FIFTH CAUSE FOR DISCIPLINE**

2 **(Re: Patient SG)**

3 **(Unprofessional Conduct/Gross Negligence/Inadequate Records)**

4 45. Respondent first began treating Patient SG, an elderly woman and family member of
5 Respondent's, in 1998. Although not documented in the patient record, Respondent reported at
6 his Medical Board interview on November 4, 2014, that SG's diagnoses include major depressive
7 disorder, generalized anxiety disorder, sleep disorder (insomnia), arthritis, osteoporosis, gastritis,
8 colitis, cholecystitis with gall stones, chronic sinusitis, and hypothyroidism. Respondent also
9 reported that SG's medical history includes uterine cancer and hysterectomy in 1992, spinal
10 surgery for spinal stenosis in 1993, and bilateral carpal tunnel syndrome for which she had
11 surgery on the right hand in either 2013 or 2014.

12 46. Respondent's records document that during 2008 through September 2014, he saw
13 Patient SG monthly or every other month. Respondent reported that he sees SG both in his office
14 and at her apartment. Respondent reported that he shares an office with the physician who has
15 been SG's primary care physician (PCP) for the last nine years.

16 47. Respondent's records document that during 2008 to 2014, medications he prescribed
17 to SG included Prozac, temazepam, clonazepam, Seroquel, and at times, Ativan, Vicodin,
18 Adderall, and Compazine. Respondent routinely failed to document the medication strength,
19 dosage, and/or quantity of the prescribed medications. Numerous progress notes simply note that
20 medications were refilled without listing the particular medications that were refilled.
21 Respondent's records for Patient SG do not include a medication list. Pharmacy prescribing
22 records for Patient SG indicate that she received prescriptions approximately every other month
23 for Wellbutrin 150 mg., #30 or #60, prescribed by Respondent. Respondent's medical records do
24 not document the ongoing prescribing of Wellbutrin to SG.

25 48. Pharmacy prescribing records for SG indicate that from September 2008 to March
26 2014, Respondent prescribed antibiotic medications, such as azithromycin, amoxicillin,
27 ciprofloxacin, and sulfamethoxazole, to SG approximately 37 times. Respondent's records do not
28 document that he prescribed any antibiotic medications to SG, the medical indication for such

1 prescribing, nor SG's response to the prescribed medications. Pharmacy prescribing records also
2 indicate that Respondent prescribed nitroglycerin³ on January 3, 2009 and December 10, 2013;
3 and, VESIcare⁴ on June 15, 2013, and January 6 and July 7, 2014 to SG. Respondent's records do
4 not document that he prescribed either of these two medications to SG, the medical indications for
5 such prescribing, nor SG's response to these medications.

6 49. At his Medical Board interview, Respondent reported that he consulted with SG's
7 other treating physicians, such as her PCP and ENT physicians, regarding the prescribing of non-
8 psychiatric medications. Respondent's records for SG fail to document consultation with any of
9 SG's other treating physicians.

10 50. Respondent is guilty of unprofessional conduct and subject to disciplinary action
11 under section 2234, and/or 2234 (b), and/or 2266 of the Code in that Respondent was grossly
12 negligent in his care and treatment of Patient SG and he failed to keep adequate and accurate
13 records related to his care and treatment of SG, including but not limited to the following:

14 A. Respondent failed to document medical indication for the repeated prescribing of
15 antibiotic medications, and the prescribing of nitroglycerin and VESIcare.

16 B. Respondent failed to document a treatment plan and periodic review of the patient's
17 treatment plan and medications, including response to treatment.

18 C. Respondent failed to document in the patient record all medications prescribed to SG,
19 and/or, the strength, dosage, and/or quantity of the prescribed medications.

20 D. Respondent failed to document in the patient record consultations with SG's other
21 treating physicians.

22 E. Respondent failed to limit his care and treatment of SG, a family member, to medical
23 emergencies and/or care on a short-term basis.

24 F. Significant portions of Respondent's progress notes are illegible.

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27 ³ Nitroglycerin is used to treat, among other things, chest pain.

28 ⁴ VESIcare is used to treat symptoms of overactive bladder and incontinence.

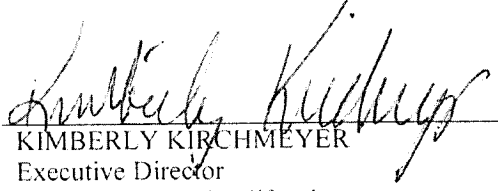
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PRAYER

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 A 56467, issued to Alexander Grinberg, M.D.;
2. Prohibiting Alexander Grinberg, M.D. from supervising physician assistants pursuant to section 3527 of the Code;
3. Ordering Alexander Grinberg, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and,
4. Taking such other and further action as deemed necessary and proper.

DATED: February 23, 2015



KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2014409231