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

In the Matter of the Accusation Against:	)	
	)	
	)	
GREGORY SEAN PANICCIA, M.D.	)	**Case No. 800-2014-004873**
	)	
Physician's and Surgeon's Certificate No. G 76979	)	
	)	
	)	
Respondent	)	
	)	

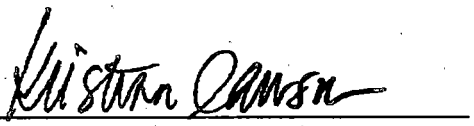
DECISION

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 7, 2017.

IT IS SO ORDERED: November 7, 2017.

MEDICAL BOARD OF CALIFORNIA



Kristina Lawson, J.D., Chair
Panel B

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **GREGORY SEAN PANICCIA, M.D.** **1908 Sweetwater Road** **National City, CA 91950** **Physician's and Surgeon's Certificate No. G 76979** Respondent.	Case No. 800-2014-004873 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

2. Respondent Gregory Sean Paniccia, M.D. (Respondent) is represented in this proceeding by attorney Randy Berg, Esq., of Gittler & Bradford, whose address is: 10537 Santa Monica Blvd., 3rd Floor, Los Angeles, CA 90025-4952.

3. On or about June 28, 1993, the Board issued Physician's and Surgeon's Certificate No. G 76979 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-004873, and will expire on September 30, 2018, unless renewed.

JURISDICTION

4. On May 1, 2017, Accusation No. 800-2014-004873 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 1, 2017. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2014-004873 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-004873. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2014-004873.

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

CONTINGENCY

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

11. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any

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member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

12. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

13. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 76979 issued to Respondent Gregory Sean Paniccia, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for six (6) years from the effective date of the Decision and Order on the following terms and conditions.

1. **CONTROLLED SUBSTANCES - TOTAL RESTRICTION**. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act. Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the

meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **MEDICAL RECORD KEEPING COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course

provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **CLINICAL COMPETENCE ASSESSMENT PROGRAM**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations. Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3)

calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. **SOLO PRACTICE PROHIBITION**. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

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

Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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

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

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

11. **GENERAL PROBATION REQUIREMENTS**.

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

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

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

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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

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

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

application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

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

DATED: 7-26-17 Gregory Paniccia, M.D.

GREGORY SEAN PANICCIA, M.D.
Respondent

I have read and fully discussed with Respondent Gregory Sean Paniccia, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7-26-17

RANDY BERG, ESQ.
Attorney for Respondent

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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: 8/7/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-004873

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **GREGORY SEAN PANICCIA, M.D.** **1908 Sweetwater Road** **National City, CA 91950-7628** **Physician's and Surgeon's Certificate No. G76979,** **Respondent.**	**Case No. 800-2014-004873** **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about June 28, 1993, the Board issued Physician's and Surgeon's Certificate No. G76979 to Gregory Sean Paniccia, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on September 30, 2018, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

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

". . .

"(b) Gross negligence.

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

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

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

". . ."

6. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or

administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states:

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

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as

determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients R.M., K.L.C., R.MA., R.R., and R.P., as more particularly alleged hereinafter:

Patient R.M.

11. On or about January 29, 2013, respondent had his first visit with patient R.M., a then-29 year old female referred to respondent after the patient's previous psychiatrist retired. There is no indication that respondent attempted to obtain medical records from prior treating physicians and/or mental health professionals. Patient R.M. was previously diagnosed with bipolar disorder and had a psychiatric history which included, but was not limited to, two prior inpatient hospitalizations when she was 19 and 24 years old following suicide attempts. Patient R.M.'s substance abuse history included abusing and/or being dependent on alcohol, methamphetamine and heroin. Patient R.M. reported she was not currently using drugs or alcohol. There was no

documented inquiry as to the time frames and/or amounts for the patient's alcohol and drug abuse set forth in her history; or whether there were any relapses, past treatment for the alcohol and substance abuse and/or whether she was currently seeing any other treating physicians. Patient R.M.'s social history included arrests for domestic violence, prostitution, and petty theft; and she reported being paranoid about a man who had attacked her and further reported having suffered head trauma from "fights." Respondent's assessment was Bipolar Disorder Type I, Post Traumatic Stress Disorder (PTSD), Seasonal Affective Disorder and Social Phobia. The treatment plan included increasing Neurontin (gabapentin) to 600 mg b.i.d. (twice a day); resume Xanax (alprazolam)[1] 2 mg q.i.d. (four times a day); and return to clinic in 4 to 6 weeks. Neither gabapentin nor alprazolam are standard treatments for Bipolar Disorder.

12. On or about March 5, 2013, patient R.M. had a follow up visit with respondent who raised concerns about upcoming surgery to her arm and a seizure that she attributed to Lamictal. According to the progress note for this visit, patient R.M. was requesting Soma (carisoprodol) or Valium (diazepam)[2] for muscle spasms. Respondent further documented that patient R.M.'s "mood was improving, but has swings," pain affected her sleep, her appetite had decreased with the patient losing ten pounds; and she was feeling guilt, worthlessness and hopelessness over her illness. The patient's current medications were listed as Neurontin (gabapentin) 600 mg b.i.d., Xanax (alprazolam) 2 mg q.i.d. and Lamictal 25 mg b.i.d. (with a notation of first pill today).

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[1] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[2] Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

Respondent made no inquiry or mention that between the last visit and this visit patient R.M. had received a total of 260 tablets of oxycodone/APAP 10/325 mg. Respondent's assessment was Bipolar Disorder Type I, Seizure Disorder and Muscle Spasms; and his treatment plan was to add Baclofen (muscle relaxant generally used to treat muscle spasms or spasticity) 10 mg b.i.d. to be increased after seven days to 20 mg b.i.d., continue present medications and return to clinic in 4 to 6 weeks.

13. On or about April 25, 2013, patient R.M. had a follow up visit with respondent in which she reported, among other things, that she recently had the flu, she was taking her medications, that she wanted Ativan[3] over the Xanax due to seizures, she was still taking the Lamictal, she was sleeping on and off, her appetite was "ok," her mood was improving, she was "becoming interested," there was no reported psychosis or suicidal ideation and she was scheduled to see a neurologist on May 1, 2013, for her seizures. The patient's current medications were listed as Neurontin 600 mg b.i.d., Xanax 2 mg q.i.d. and Lamictal 25 mg b.i.d. Respondent made no inquiry or mention that between the last visit and this visit, that patient R.M. had received a total of 290 tablets of oxyocodone/APAP 10/325 mg. Respondent's assessment was Bipolar Disorder Type I, Seizure Disorder and Muscle Spasms; and his treatment plan was to increase the Lamictal to 50 mg b.i.d. and the Neurontin to 600 mg t.i.d. (three times a day); discontinue Xanax and replace with Ativan 2 mg q.i.d. and return to clinic in 4 to 6 weeks.

14. According to patient M.R.'s Controlled Substances Utilization and Evaluation System (CURES) report, she filled prescriptions for Suboxone[4] (#6) on May 1, 2013; and Suboxone (#90)

[3] Ativan® (lorazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of Ativan® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Ativan®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[4] Suboxone® (buprenorphine and naloxone) is a Schedule III controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of opioid dependence and should be used as part of a complete treatment program to include counseling and psychosocial support.

on May 29, 2013, that were prescribed by another health care provider.

15. On or about May 30, 2013, patient R.M. had a follow up visit with respondent in which he documented, among other things, that the Ativan helped patient R.M.'s seizures but not her anxiety, she had pain in her back, arms and legs; less muscle spasms on the Baclofen; that she was forgetful, felt like she couldn't work, had "bad visions in her head," and that her neurologist, whose name was not documented in the progress note, wanted her on Lamictal at 20 mg and Depakote, her neurologist had raised the Neurontin to 1200 mg b.i.d.; she "wants to die when she has bad visions;" she sits in her room and locks the door because she feels people are out to get her; and she had insomnia. The current medications were listed as Neurontin 600 mg b.i.d. (increased to 1200 mg b.i.d.), Ativan 2 mg q.i.d. and Lamictal 50 mg b.i.d. There was no mention or inquiry about patient R.M. recently starting on Suboxone, as indicated on her CURES report. Respondent's assessment was Bipolar Disorder Type I; and his treatment plan was Neurontin and Lamictal per directions of neurologist; discontinue Ativan due to lack of response; resume Xanax 2 mg q.i.d.; add Ambien[5] 5-10 mg at bedtime (HS) as needed (PRN) for sleep; and return to clinic in 4 to 6 weeks.

16. On or about July 16, 2013, patient R.M. had a follow up visit with respondent in which he documented, among other things, that the patient had an argument with another person in the waiting room, she was going to enter a dual diagnosis program, she had pain in her arms and muscle spasms, and that she was now on Tegretol, a medication to treat seizures. There was no inquiry about any comorbid substance abuse disorder that would require a dual diagnosis program. The assessment was Bipolar Disorder Type I and seizure disorder with a documented upcoming appointment with a neurologist and the treatment plan was "MSA's as per Neurology," continue Xanax, increase Baclofen 20 mg, "will sign ROI for Dr. [G]" and return to clinic in 4 to 6 weeks.

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[5] Ambien® (zolpidem tartrate), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

17. On or about August 6, 2013, patient R.M. had a follow up visit with respondent in which he documented, among other things, that she "was inpatient for 4 days" and her Baclofen was decreased to 10 mg t.i.d. The patient reported "her body went into shock from taking an extra dose of Baclofen" and her pill bottles were taken at the hospital and not returned. The assessment was Bipolar Disorder Type I and seizure disorder with a note of "sees Neurologist today" and the treatment plan was refill the patient's Xanax and Ambien, discontinue Ativan, and return to clinic in 4 to 6 weeks.

18. On or about September 10, 2013, patient R.M. had a follow up visit with respondent in which he documented, among other things, that the patient reported having a stressful month, that she "ran out of Xanax today – script due 9/13/13," she had mood swings, had been impulsively calling other people, was on Lamictal 50 mg b.i.d. for less than one week, had been in inpatient care where they did not want her on Xanax and Ambien, and that sometimes she took more Ambien than prescribed. CURES indicates that respondent prescribed hydrocodone/APAP 5/500 mg (#15) which was not documented (that was filled on September 18, 2013). The assessment was Bipolar Disorder Type I, rule out panic attacks; seizure disorder with a note that she was seeing Dr. [G] tomorrow; and migraine headaches. Respondent's treatment plan included, but was not limited to, continuing present medications (Xanax, Baclofen, Ambien, Ativan, Tegretol, Lamictol and Neurontin), add Saphris (asenapine) 5 mg b.i.d., consider Seroquel and return to clinic in 4 to 6 weeks.

19. On or about October 22, 2013, patient R.M. had a follow up visit with respondent in which he documented, among other things, that the patient had a recent second surgery on her elbow, that she saw a pain specialist and got morphine and oxycodone, she had a panic attack the day before, the narcotics made her tired in the day, and she had trouble sleeping at night. The assessment was Bipolar Disorder Type I, panic attacks, seizure disorder and migraine headaches. Respondent's treatment plan was to continue present medications, start Saphris 5 mg b.i.d., labs, and return to clinic in 4 to 6 weeks.

20. On or about January 7, 2014, patient R.M. had a follow up visit with respondent for her bipolar disorder with no narrative history documented. As of this date, respondent had

switched from handwritten progress notes to electronic medical records. Her current medications were listed as Ambien 10 mg p.r.n. sleep, Baclofen 10 mg t.i.d., Lamictal 100 mg q.a.m. (every morning), Neurontin 600 mg t.i.d., Tegretol 200 mg b.i.d., and Xanax 2 mg q.i.d. The treatment plan was listed as "Patient will call or come in if symptoms increase" and a box was checked for "continue with current treatment."

21. On or about February 18, 2014, patient R.M. had a follow up visit with respondent for her bipolar disorder with no narrative history documented. The patient was listed as not being stable on her present medications, she was depressed, noted as having "delusions" and her prognosis was listed as fair. Respondent added a prescription for Latuda (generally indicated for the treatment of patients with schizophrenia) 40 mg per day. Respondent's assessment was documented as Bipolar Disorder. Respondent's treatment plan was to add Latuda, get labs, and continue with current treatment.

22. On or about April 1, 2014, patient R.M. had a follow up visit with respondent with no narrative history documented. The patient was documented as, among other things, being stable on her medications, improved but still depressed, still having delusions, no suicidal or homicidal ideation, and having a delusional and paranoid thought process. Respondent increased the patient's Latuda prescriptions from 40 mg per day to 80 mg per day. There was no assessment indicated in the record for this visit.

23. On or about May 6, 2014, patient R.M. had a follow up visit with respondent with no narrative history documented. The patient was documented as, among other things, being stable on her medications, behavior and mood was within normal ranges, no longer having delusions, no suicidal or homicidal ideation, with a fair prognosis. Respondent continued Xanax 2 mg q.i.d. (#120); Latuda 80 mg per day (#30) and his plan was to continue with current treatment.

24. On or about July 8, 2014, patient R.M. had a follow up visit with respondent which is documented as a "Medication check-up for Bipolar Depression." The medical record for this visit, which is in a different format, is cursory, missing a narrative history and missing information in the "Family History" and "Introspective Awareness" sections of the medical record. Respondent's assessment was Bipolar Mood Disorder, Type 1, Depressed Type with

Psychotic Features. Respondent's documented treatment plan was to continue Xanax 2 mg q.i.d. and increase the Latuda to 160 mg every p.m. with dinner.

25. On or about August 5, 2014, patient R.M. had a follow up visit with respondent in which he documented that the "Patient presents for follow-up for Bipolar Disorder, Type 1, Depressed Type with Psychotic Features." There is no narrative history provided and the "Family History" section is blank. The current medications were listed as zolpidem tartrate (Ambien) 10 mg, Latuda 80 mg when, in fact, the Latuda had been increased to 160 mg at the last visit, and Xanax 2 mg. The Axis 1 assessment was documented as Bipolar Disorder, Type 1, Depressed Type with Psychotic Features. Respondent's treatment plan was to "stabilize mood" and address the problem behavior which was listed as "Depression/Insomnia/Anxiety." Respondent's treatment plan included increasing the prescription of Xanax 2 mg from four times a day to five times a day; continue Latuda 160 mg every p.m. with dinner; and resume Baclofen 10 mg b.i.d. to t.i.d.; resume Ambien 10 mg p.r.n. sleep and return to clinic in 4 to 6 weeks.

26. On or about September 16, 2014, patient R.M. had a follow up visit with respondent. The current medications were documented as zolpidem tartrate (Ambien) 10 mg, Latuda 80 mg when, in fact, the Latuda was continued at 160 mg, and Xanax 2 mg. There was no family history listed, no narrative history, and the Axis I and III diagnoses were inconsistently listed on the medical record documentation for this visit. The "Psychopharmacology" was listed as Xanax 2 mg five times a day, continue Latuda 160 mg every p.m. with dinner; discontinue Lamictal due to seizures, continue Baclofen 10 mg b.i.d. to t.i.d.; increase Ambien to 20 mg every evening p.r.n. sleep, and refill Keppra 500 mg b.i.d. The treatment plan included referral to neurologist, follow up labs and return to clinic in 4 to 6 weeks.

27. On or about December 2, 2014, patient R.M. had a follow up visit with respondent for her bipolar disorder. The current medications were documented as zolpidem tartrate (Ambien) 10 mg, Latuda 80 mg when, in fact, the Latuda was continued at 160 mg, and Xanax 2 mg. There was no narrative history and the Axis I and III diagnoses were inconsistently listed on the medical record documentation for this visit. The treatment plan for this visit was the same as for the prior visit.

28. A review of patient R.M.'s CURES report for the period of November 1, 2011, to November 12, 2014, contains indications of patient R.M.'s misuse, abuse and/or diversion of controlled substances including, but not limited to, patient R.M. filling multiple prescriptions for opioids[6] being prescribed by other physicians and being filled at different pharmacies in 2013 and 2014 and patient R.M. filling multiple prescriptions for Suboxone (buprenorphine and naloxone) in 2013 and 2014 that was being prescribed by another physician. During his interview before a Department of Consumer Affairs, Health Quality Unit (HQIU) Investigator and Medical Consultant, respondent admitted that he was not reviewing CURES while he was prescribing controlled substances to patient R.M. and, thus, was not aware of the prescribing pattern set forth in the CURES report.

29. Respondent committed gross negligence in his care and treatment of patient R.M. including, but not limited to, the following:

(a) Respondent repeatedly prescribed excessive amounts of controlled substances, including hypnotic-sedative medications and/or benzodiazepines, to a known substance abuser, without any objective and justifiable basis for prescribing such amounts of controlled substances;

(b) Respondent failed to provide any legitimate treatment for patient R.M.'s substance abuse and increased the risk of harm to her by continuing to prescribe her excessive and unjustified amounts of controlled substances;

(c) Respondent repeatedly prescribed benzodiazepines to patient R.M. while she was pregnant without any informed consent regarding the dangers associated with benzodiazepines or without reducing the

[6] As an example, during the period of January 29, 2013, to March 13, 2013 (43 days), patient R.M. obtained 550 tabs of oxycodone/APAP 10/325 mg from four different physicians. Shortly after this run, she began taking Suboxone® which is clinically indicated for the treatment of opioid dependence.

dosage of benzodiazepines to the minimal amount necessary to avoid incapacitating symptoms;

(d) Respondent repeatedly prescribed controlled substances to patient R.M. despite objective indications of abuse, misuse and/or diversion of controlled substances; and

(e) Respondent repeatedly prescribed controlled substances to patient R.M. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or without utilizing other risk screening tools.

Patient K.L.C

30. On or about May 12, 2009,[7] patient K.L.C. had her initial visit with respondent in which he documented that the patient was self-referred for major depression. She was documented as being negative for suicidal ideation, homicidal ideation, mania and psychosis. The patient's substances abuse history was listed as negative and the patient was positive for a family history of psychiatric disorders. Current medications were listed as Soma (carisoprodol)[8] one tablet q.i.d., Klonopin 2 mg t.i.d., Darvocet one tablet q.i.d. and Trazadone 100 q.h.s. Respondent's Axis I diagnoses was Major Depressive Disorder (296.32) and his treatment plan was to continue the Klonopin[9] 2 mg, increase Trazadone 200 to 300 mg q.h.s. as needed for sleep, add Pristiq 50 mg q.a.m. (morning) and return to clinic in one month.

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[7] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[8] Soma® (carisoprodol) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions.

[9] Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonipin®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

31. For the period of on or about May 13, 2009, through on or about April 20, 2010, respondent continued to see patient K.L.C. on a near monthly basis for follow up on her Axis 1 diagnosis of Major Depressive Disorder (296.32) and for medication management of her symptoms. During this time, patient K.L.C. reported continued marital strife with her husband, that she had "served husband papers" on or around January 5, 2010, that her husband, who initially had a brief period of sobriety, was "still drinking," and on April 20, 2010, that "[d]ivorced (sic) now finalized" and "[l]iving in mobile [home] now with ex-husband [with] less conflict."

32. On or about May 21, 2010, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient was feeling distressed about her brother being arrested again for driving under the influence and her labs had been completed. Respondent's assessment was Major Depressive Disorder (296.32) with residual symptoms and Insomnia (327.02) with some symptoms. Current medications were listed as Sercone 300 mg b.i.d., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril[10] 30 mg q.h.s. p.r.n. sleep, and Abilify 10 mg h.s. The treatment plan was to increase Abilify to 15 mg q.h.s. and return to clinic in 5 weeks.

33. On or about August 31, 2010, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient "appears emaciated" and "weight today = 86 lbs." The patient reported problems with sleeping, no appetite, that she was very sad, and she had guilt over giving her husband a second chance. Respondent's assessment was Major Depressive Disorder (296.32) with increased depression, Insomnia (327.02) symptoms still present and migraine headaches with the patient asking for Depakote. Respondent's treatment plan was to continue with current medications (Serzone, Soma, Valium and Restoril), discontinue Abilify due to complaints of akathisia (restlessness) and add Depakote (VPA) at 250

[10] Restoril® (temazepine), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Restoril® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Restoril®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

mg b.i.d., and then increasing to 500 mg b.i.d., after 10 days.

34. On or about October 5, 2010, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient appeared better, she was tearful when discussing her current life situation, she had stopped Serozone upon starting the Depakote (VPA), and her weight had increased to 92.8 pounds. Respondent's assessment was Major Depressive Disorder (296.32) improved, Insomnia (327.02), with migraine headaches noted as still present. Respondent's treatment plan was to continue with current medications (Depakote (VPA), Serzone, Soma, Valium and Restoril) with Darvocet p.r.n. pain., follow up on VPA level and return to clinic in two months.

35. On or about November 30, 2010, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient was having migraines and depression, not eating well, having trouble sleeping, was tired, and having feelings of worthlessness. The patient denied suicidal and homicidal ideation. Labs were reviewed, including the VPA level. The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s. and Darvocet p.r.n. pain. The assessment was Major Depressive Disorder (296.32) with an increase in depressive symptoms, Insomnia (327.02) and migraine headaches. Respondent's treatment plan was to continue with current medications and to increase the Depakote to 1000 mg b.i.d. and recheck VPA level in two weeks; Midrin was also added for the patient's migraine headaches; and return to the clinic in four to six weeks.

36. On or about January 5, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient was "very anxious [and] tremulous today, she had seen another doctor recently for a social security re-evaluation who indicated patient K.L.C. had post-traumatic stress disorder. The patient indicated she was sad, had crying spells, no joy, she was angry, irritable, very overwhelmed, and was having nightmares. The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s., Darvocet p.r.n. pain, and Trazadone 150 mg q.h.s. (which was not listed in the last progress note). The assessment was Major Depressive Disorder (296.32) with an increase in symptoms, Insomnia (327.02) with a note of "slept on Restoril/Trazadone," tremor in hands,

and migraine headaches. Respondent's treatment plan was to continue with current medications, check VPA level, add Inderol 10 mg q.a.m. for the tremors, and "rechallenge" Paxil 10 mg q.a.m. for seven days and then increase to 20 mg., and return to clinic in one month.

37. On or about February 1, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient was upset because her social security request was denied after she was deemed to no longer be physically disabled, less tremors on Inderal, and with the patient reporting the Paxil was working well at 20 mg. The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s., Darvocet p.r.n. pain, Trazadone 50 mg q.h.s. (listed as 150 mg in the prior progress note), Inderal 10 mg q.a.m., and Paxil 20 mg q.a.m. The assessment was Major Depressive Disorder (296.32), Insomnia (327.02), tremor in hands less with the Inderal, and migraine headaches. Respondent's treatment plan was to continue with current medications, increase Inderal to 80 mg, return to clinic in four to six weeks, and referral to an attorney for social security appeal.

38. On or about March 22, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient complained of having no money and no place to live, being "very angry," upset with her ex-husband, she had decreased Depakote (VPA) "due to sedation," and she didn't like the Paxil because "it doesn't help me." The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s., Darvocet p.r.n. pain, Trazadone 150-300 mg q.h.s., Inderal 80 mg q.a.m., Paxil 20-40 mg q.a.m. The assessment was Major Depressive Disorder (296.32) increase in symptoms, Insomnia (327.02) "broken sleep," tremor improved, and migraine headaches. Respondent's treatment plan was to continue with current medications, add Zoloft 50 mg q.a.m., discontinue Paxil, and return to clinic in four to six weeks.

39. On or about April 21, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, the patient's displeasure with her ex-husband's daughter taking over her house and the patient having "no response to Zoloft." The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s.,

Trazadone 150-300 mg q.h.s., Inderal 80 mg q.a.m. and Zoloft 50 mg q.a.m. The assessment was Major Depressive Disorder (296.32) depressive symptoms, Insomnia (327.02), tremor less on Inderal, and migraine headaches. Respondent's treatment plan was to continue with current medications, increase Zoloft to 100 mg q.a.m., referral to two other people for social security appeal, and return to clinic in four to six weeks.

40. On or about June 16, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, conflict with her ex-husband due to his daughter being at her house, the ex-husband and step-daughter both using alcohol, patient feeling no joy, pleasure, very tired, and having low appetite. The current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s., Trazadone 150-300 mg q.h.s., Inderal 80 mg q.a.m. and Zoloft 100 mg q.a.m. The assessment was Major Depressive Disorder (296.32) depressive symptoms, Insomnia (327.02), tremor, migraine headaches, and back pain with patient "asking for Tramadol 50 mg #120 [because she] cannot afford Dr. [N.M.] at this time." Respondent's treatment plan was to continue with current medications, increase Zoloft to 200 mg q.a.m., refill the Valium for another 3 months, add Ultram 50 mg q.i.d. p.r.n. pain; and follow up at Helping Hand Counseling in four to six weeks.

41. On or about September 6, 2011, patient K.L.C. had a follow up visit with respondent who documented, among other things, continued problems with the patient's ex-husband and his daughter, that the patient was "going nuts, " "isolates in [her] room," was sleeping with Trazadone and Restoril, and still "no appetite." The current medications were listed as Trazadone, Restoril, Tramadol, Valium, Soma and Zoloft 50 mg q.a.m. (the last chart note recorded Zoloft at 100 mg). The assessment was Major Depressive Disorder (296.32) "still depressed." The treatment plan was to continue with current medications, increase Zoloft 100 mg q.a.m. and return to clinic "6-8 weeks – 4 months."

42. On or about February 9, 2012, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient's ex-husband had been "belligerent [and] drunk," the patient "isolates in [her] room," she was compliant with her medications, and her weight was 90 pounds. The current medications were listed as Trazadone 150 mg q.h.s., Zoloft

100 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram 50 mg q.i.d. The assessment was Major Depressive Disorder (296.32) stable and Insomnia (327.02) stable. Respondent's treatment plan was to continue with current medications and return to clinic in 3 months.

43. On or about May 8, 2012, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient was feeling sad, had increased crying spells, somewhat low appetite, she was tired and sleeping during the day, overwhelmed, and reading one bible chapter a day. The current medications were listed as Trazadone 150 mg q.h.s., Zoloft 100 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram 50 mg q.i.d. The assessment was Major Depressive Disorder (296.32) increase in symptoms, Insomnia (327.02) "broken sleep-sleeps in day," and back pain from scrubbing linoleum floor, in bed for 2 days, with patient indicating Ultram was "too weak." Respondent's treatment plan was to continue with current medications, increase Ultram 100 mg q.i.d. p.r.n. pain, and return to clinic in 4 to 6 weeks.

44. On or about January 22, 2013, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient, who had been out-of-state, gained some weight, her appetite was doing better, she was staying with her ex-husband, who was still drinking, and she was "relatively compliant with meds." Weight was recorded as 127 pounds. The current medications were listed as Trazadone 150-300 mg q.h.s., Zoloft 200 mg q.a.m. (which was 100 mg more than the last recorded Zoloft level), Tramadol 50 mg q.i.d. (not listed on the medications list for the last visit), Soma 350 mg q.i.d., Valium 10 mg q.i.d., and Restoril 30 mg p.r.n. sleep. Ultram 100 mg q.i.d. was documented for the prior visit but not listed on the progress note for this visit and there was no documentation as to why the Ultram was discontinued if, in fact, it was discontinued. The assessment was Major Depressive Disorder (296.32) with depressive symptoms. Respondent's treatment plan was to increase Zoloft to 150 mg q.a.m., provided a referral to North County "access line" for a pain specialist.

45. On or about April 24, 2013, the office visit for patient K.L.C. was cancelled because she reported that she "fell last night and hurt herself."

46. On or about May 15, 2013, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient, was "walking with cane (back pain)," the "Tramadol doesn't work," she had started physical therapy exercises, there were still issues with her ex-husband's alcohol use, and the Zoloft was upsetting her stomach. The current medications were listed as Trazadone 100 mg q.h.s., Zoloft 100 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram 100 mg q.i.d. The assessment was Major Depressive Disorder (296.32) stable, Insomnia (327.02) stable, "Back Spasms – Soma," and "Lower back/Hip/knee pain – R.A. in hands/back/ [left] foot." Respondent's treatment plan was to continue with current medications and return to clinic in "4 - 6 weeks – chose 3 months."

47. On or about June 26, 2013, patient K.L.C. had a follow up visit with respondent who documented, among other things, that the patient had a DV (domestic violence) incident with her ex-husband, she "brought court papers – restraining order," she "claims to be on 200 mg Zoloft not 150 mg as ordered on 5/15/13," she was sleeping most of the day, and feeling depressed. The current medications were listed as Valium 10 mg q.i.d., Zoloft 100 mg q.a.m., Ultram 100 mg q.i.d., Soma 350 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Trazadone 75-150 mg q.h.s. The assessment was Major Depressive Disorder (296.32) "still depressed," L/S (lumbosacral) pain/arthritis – also arthritis in hands/knees/feet/back – Ultram not working." Respondent's treatment plan was to increase Zoloft 200 mg q.a.m., discontinue Ultram for "lack of efficacy," add Tylenol ES 500-1000 mg t.i.d. p.r.n. pain, and return to clinic in 4-6 weeks.

48. On or about September 22, 2013, patient K.L.C. had a follow up visit with respondent who documented, among other things, that she was in the same living situation, her ex-husband has to take "DUI/husband classes," the assault charges against her ex-husband were dropped, she didn't get the Tylenol ES filled, her "spirits are high" from attending church, sleep was okay, "appetite 'waned,'" and the patient had "energy to spare." The current medications were listed as Trazadone 150-300 mg q.h.s. (which was different than the 75-150 mg that was recorded for her piror visit), tramadol (Ultram) 100 mg q.i.d., Soma 350 mg q.i.d., Zoloft 200 mg q.a.m., Temazapam (restoril) 30 mg q.h.s. p.r.n. sleep , and Valium 10 mg q.i.d. The assessment was Major Depressive Disorder (296.32) "residual symptoms." Respondent's treatment plan was to

start Tylenol ES 500-1000 mg t.i.d. p.r.n. pain, discontinue Tramadol, and return to clinic in 3 months.

49. On or about January 22, 2014, patient K.L.C. had a follow up visit with respondent with no narrative history documented. The current medications were listed as Trazadone 150-300 mg q.h.s., tramadol (Ultram) 100 mg q.i.d., carisoprodol (Soma) 350 mg q.i.d., Zoloft 100 mg q.a.m., temazapam (Restoril) 30 mg q.h.s. p.r.n. sleep , and Valium (diazepam) 10 mg q.i.d. The assessment was Major Depressive Disorder (296.32). Respondent's treatment plan was to change Zoloft to 100 mg q.a.m., and continue other current medications.

50. On or about April 23, 2014, patient K.L.C. had a follow up visit with respondent with no narrative history documented. The current medications were listed as carisoprodol (Soma) 350 mg q.i.d., Valium (diazepam) 10 mg q.i.d., temazapam (Restoril) 30 mg q.h.s. p.r.n. sleep, Trazadone 150-300 mg q.h.s. p.r.n. sleep, and Zoloft 100 mg q.a.m. There was no assessment documented for this visit. The apparent treatment plan was to continue current medications.

51. A review of patient K.L.C.'s CURES report for the period of November 1, 2011, to November 12, 2014, contained indications of patient K.L.C.'s misuse, abuse and/or diversion of controlled substances including, but not limited to, obtaining large amounts of carisoprodol (Soma) 350 mg (#360) and in 2012 and 2013 and diazepam (Valium) 10 mg (#360) in 2013.

52. Respondent committed gross negligence in his care and treatment of patient K.L.C. including, but not limited to, the following:

(a) Respondent repeatedly prescribed excessive amounts of controlled substances, including, but not limited to, hypnotic-sedative medications and/or benzodiazepines, without any objective and/or justifiable basis for prescribing such amounts of controlled substances; and when considering some of the other controlled substances that were being prescribed to patient K.L.C.;

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(b) Respondent repeatedly prescribed excessive amounts of controlled substances, including benzodiazepines, such as Temazepam and Diazepam, in combination with Soma, which were not justified based on the patient's clinical presentation; and

(c) Respondent repeatedly prescribed controlled substances to patient K.L.S. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or without utilizing other risk screening tools.

Patient R.MA.

53. On or about August 30, 2011, patient R.MA., a then twenty year old male, who was referred by another physician "for medication," had his initial visit with respondent. According to the intake documents, the patient began experiencing depression at age 17, when his "problems began." His prior medications were listed as Ambien, Klonopin, Seroquel, Tegretol, Wellbutrin XL and Prozac and his current medications were "Klonopin from a friend" 2 mg b.i.d., and Xanax 2 mg b.i.d. The patient's substance abuse history was positive for beer, liquor, THC (marijuana) and "pills." Patient R.MA. described a traumatic childhood and at least one prior arrest in April 2013[11] for "DUI/Possession of cocaine." Respondent documented that the patient was "just intoxicated on THC/ETOH (alcohol)/ Club pills" and that he took a "glass bottle to back of head 8/25/11" and "fell on [his] face 2 months ago – interaction between ETOH [and] Tegretol." Respondent's Axis I diagnoses was Major Depressive Disorder, recurrent, moderate (296.32) and Insomnia (327.02) and the treatment plan was continue Klonopin 2 mg b.i.d., Xanax 2 mg b.i.d., add Paxil 10 mg q.a.m. for 7 days and then increase to 20 mg q.a.m.; add Trazadone 50-150 mg q.h.s. p.r.n. sleep and return to clinic in 4-6 weeks.

54. On or about October 6, 2011, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient was "not too good," having conflict with his father, he "uses extra Xanax, Trazadone," and he was smoking ½ ounce of marijuana per day

[11] Although this note is dated August 30, 2011, it indicates patient R.MA. had prior arrest in April 2013[11] for "DUI/Possession of cocaine.

to help with sleep. The current medications were listed as Xanax 2 mg t.i.d. – q.i.d., Paxil 20 mg q.a.m. "off last few days" and Trazadone discontinued. The assessment was Major Depressive Disorder (296.32) still depressed and Insomnia (327.02) not responding to Trazadone. Respondent's treatment plan was to increase Xanax 2 mg t.i.d. – q.i.d., increase Paxil to 40 mg q.a.m., discontinue Trazadone, add Lunesta[12] 3 mg q.h.s. p.r.n. sleep with a note to "consider Remeron" and return to clinic in 6 weeks.

55. On or about November 22, 2011, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient's Xanax was confiscated at the airport and he had to come back early from Las Vegas "due to being out of meds," he was not sleeping well, he had "used friend's Valium 10 mg q.i.d." and, according to respondent, "describes conditions symptoms of ADHD – poor focus and concentration – responded to friends Adderall." The current medications were listed as Paxil 40 mg q.a.m., Xanax 2 mg t.i.d. – q.i.d. p.r.n. anxiety, and "Lunesta – never filled." The assessment was Panic Disorder (300.01) with a note of "[increased] attacks off Xanax [and] Okay on Valium," Major Depressive Disorder (296.32) "not responding to Paxil," Insomnia and ADHD (Attention Deficit Hyperactivity Disorder (314.00). Respondent's treatment plan was discontinue Paxil due to no response; discontinue Xanax due to "rebound anxiety," add Valium 10 mg q.i.d. p.r.n. anxiety, add Remeron 7.5–15 mg q.h.s. p.r.n. sleep, and add Adderall[13] 5-10 mg b.i.d., and return to clinic in one month.

56. On or about November 29, 2011, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient reported "the Valiums are weak, but

[12] Lunesta® (eszopiclone), a sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat insomnia.

[13] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

stopping the shaking, that he wanted to go back on Xanax because he "sleeps better," and that his "focusing [was] better." The current medications were listed as Valium 10 mg q.i.d. 6 per day p.r.n. anxiety, Remeron 15 mg q.h.s., and Adderall 5-10 mg b.i.d. with a note that Adderall 10-15 mg was discontinued. The assessment was Panic Disorder (300.01), Major Depressive Disorder (296.32) "not responding to Paxil," Insomnia, ADHD (314.00), with a note, which applied to each condition, indicating "improved but anxious." Respondent's treatment plan was to discontinue Valium – poor response, add Xanax 2 mg q.i.d. p.r.n. anxiety, and return to clinic in 3 weeks.

57. On or about December 22, 2011, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient was having issues with his father and the patient's business, he ran out of Xanax and Adderall early, Remeron was not helping for sleep, and he had "some sadness [and] some panic attacks." The current medications were listed as Remeron 15 mg q.h.s., Adderall 2 mg 5-10 mg b.i.d. (10-20 mg per day), and Xanax 2 mg q.i.d. p.r.n. with a note of "(5-6 x day)." The assessment was Panic Disorder (300.01) "sporadic attacks," Major Depressive Disorder (296.32) "some depression," Insomnia "sleeps on Xanax," ADHD (314.00) "struggles with focus and concentration on Adderall 15 mg b.i.d. Respondent's treatment plan was to increase Remeron to 30 mg q.h.s., increase Adderall to 20 mg b.i.d. (40 mg per day), refill Xanax 2 mg q.i.d. p.r.n. anxiety (one week early) with a note that "will change to 5-6 a day p.r.n. anxiety[;]" and return to clinic in 4 to 6 weeks.

58. On or about January 19, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, "MRI" (without any specific details about the MRI), that the patient was "asking for cough syrup with codeine," he had been out of work for 10 days and had been on antibiotics, and that he was having "trouble sleeping." The current medications were listed as Remeron 30 mg q.h.s., Adderall 20 mg b.i.d., and Xanax 2 mg p.r.n. six (6) per day." The assessment was Panic Disorder (300.01), Major Depressive Disorder (296.32), Insomnia, and ADHD (314.00) – with a note indicating "stable [as to each condition], but has partial response to Adderall." Respondent's treatment plan was to increase Adderall to 20 mg q.i.d. (80 mg per day) and return to clinic in 4 weeks.

59. On or about February 16, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient "[a]lmost got DUI due to Xanax, police confiscated 2 bottles of pills [and his] [c]ar was impounded...," the police confiscated his "medical THC card," he had a "[b]izarre feeling in a.m. from Remeron," and some "panic attacks new." The current medications were listed as Remeron 30 mg q.h.s., Adderall 20 mg q.i.d., and Xanax 2 mg 4-6 tabs per day (8-12 mg per day). The assessment was Panic Disorder (300.01) '[increased] panic off Xanax," ADHD (314.00) stable, Major Depressive Disorder (296.32) stable, and Insomnia (327.02) "broken sleep off Xanax." Respondent's treatment plan was to refill Xanax and Adderall, discontinue Remeron, and return to clinic in 1 month.

60. On or about April 17, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient appeared tired and sad, was having "issues with father," claimed his anxiety was worse and only Xanax helped, that he was only taking the Xanax and Adderall, and that he "sleeps on Xanax." The assessment was Panic Disorder (300.01) '[increased] panic off Xanax," ADHD (314.00) stable, Major Depressive Disorder (296.32) stable, and Insomnia (327.02) "broken sleep off Xanax." The current medications were listed as Adderall 20 mg q.i.d., and Xanax 2 mg six (6) a day and "takes up to 8 [per] day" (16 mg per day). The assessment was Panic Disorder (300.01) "some anxiety," ADHD (314.00) "stable/anorexia," Major Depressive Disorder (296.32) "some depression," and Insomnia (327.02). Respondent's treatment plan was "[h]ad trials of Paxil/Prozac [-] Will add Zoloft 50 mg q.a.m.," refill Adderall, and return to clinic in 4-5 weeks.

61. On or about May 31, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient was having "family issues," "using a lot of Xanax," the Adderall decreased his appetite, he gets up later in the morning, and "may get DUI for Xanax – may go to court." The current medications were listed as Adderall 20 mg q.i.d., and Xanax 2 mg "8–9 [per] day" (16-18 mg per day). The assessment was Panic Disorder (300.01) "improved on Xanax," ADHD (314.00) "stable," Major Depressive Disorder (296.32) "[increased] depression," and Insomnia (327.02) "okay." Respondent's treatment plan was to

increase Zoloft to 100 mg q.a.m., refill Adderall, and change Xanax 2 mg to seven per day and 3 tabs q.h.s. (10 tabs a day for a total of 20 mg of Xanax per day), and return to clinic in one month.

62. On or about June 28, 2012, patient R.MA. was a no show for his appointment. Respondent called patient R.MA. and documented, among other things, that the patient was still having conflict with his father, the patient was going on vacation to Dubai and he wanted "3 month script for trip to Middle East." The current medications were listed as Adderall 20 mg q.i.d., Xanax 2 mg to seven per day and 3 tabs q.h.s. (20 mg per day), and Zoloft 100 mg q.a.m. The assessment was Panic Disorder (300.01) "in remission, but relies on Xanax," ADHD (314.00) "uses Adderall for work to focus/concentrate," Major Depressive Disorder (296.32) "stable," and Insomnia (327.02) "sleeps." Respondent's treatment plan was "one (1) month script for Adderall [and] three (3) month scripts for Xanax/Zoloft – Zoloft @ 200 mg" (900 tabs of Xanax[14] and 180 tabs of Zoloft) and return to clinic in 3 months.

63. On or about September 4, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient's girlfriend wanted to break up with him, the patient "has a felony case – caught with gun in house" the patient has no car, his driver's license was suspended, and he stopped taking Zoloft one month ago. The current medications were listed as Adderall 20 mg q.i.d., Xanax 2 mg 10 per day (20 mg total per day), and Zoloft 200 mg q.a.m. (discontinued last month). The assessment was Panic Disorder (300.01) "sporadic attacks," ADHD (314.00) "[increased] Sx [symptoms] off Adderall," Major Depressive Disorder (296.32), and Insomnia (327.02) "broken sleep." Respondent's treatment plan was to refill Adderall 20 mg q.i.d., decrease Xanax to 4 mg q.i.d. "(16 mg per day total)" and return to clinic in 1 month.

64. On or about September 27, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient was "out of Xanax early takes an extra 2

[14] During his interview before a Department of Consumer Affairs, Health Quality Unit (HQIU) Investigator and Medical Consultant, respondent confirmed that he prescribed 900 tablets of Xanax and claimed that the prescription was cancelled by phone. There is a notation in his medication log for June 28, 2012, that indicates "CX by phone." According to patient R.MA.'s CURES report, patient R.MA. filled a prescription for Xanax 2 mg (#300) on July 31, 2012.

tablets (4 mg) at h.s. (bedtime) to sleep and 'overall doing well.' " The current medications were listed as Adderall 20 mg q.i.d., Xanax 4 mg q.i.d. "(4 mg 5x /day PRN)." The assessment was Panic Disorder (300.01), ADHD (314.00), Major Depressive Disorder (296.32), and Insomnia (327.02). Respondent's treatment plan was to refill Adderall and Xanax, add Ambien 5-10 mg q.h.s. p.r.n. sleep, and return to clinic on October 2, 2012. The patient was a no-show for the office visit on October 2, 2012

65. On or about November 1, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient "went to jail," his "girlfriend left him," he had poor sleep from 6:00-8:00 a.m. on Ambien, he asked for Seroquel for sleep, no ETOH, and "[c]ashed out lawyers – will go to court." The current medications were listed as Adderall 20 mg q.i.d., Xanax 4 mg q.i.d., and Ambien 5-10 mg q.h.s. p.r.n. sleep. The assessment was Panic Disorder (300.01) "more anxious...," ADHD "Inattentive Type" (314.00), Major Depressive Disorder (296.32) "had trials of Prozac, Zoloft, Paxil," and Insomnia (327.02) "poor sleep on Ambien." Respondent's treatment plan was to refill Adderall 20 mg q.i.d., continue Xanax 4 mg q.i.d., add Seroquel XR 50-400 mg q.h.s. p.r.n. sleep, "consider antidepressant – has had sporadic seizures in past...," and return to clinic in one month.

66. On or about November 29, 2012, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient lost his wallet, had issues with his girlfriend, lost his license and insurance card, and has low income. The current medications were listed as Adderall 20 mg q.i.d., Xanax 4 mg q.i.d., and Seroquel XR 400 mg q.h.s. The assessment was Panic Disorder (300.01), ADHD "Inattentive Type" (314.00), Major Depressive Disorder (296.32), and Insomnia (327.02) with a note for all that indicated "mixed depressive anxiety." Respondent's treatment plan was to add Viibryd (an antidepressant) to be gradually increased to 40 mg q.a.m. and return to clinic in one month.

67. On or about February 5, 2013, patient R.MA. had a cell phone consultation with respondent, who documented, among other things, that the patient was, or had been, in Los Angeles for business and left his prescription for Xanax in Los Angeles. He was now asking for Halcion, stated he needs more Adderall and that he wanted to take five per day (150 mg), he had

short term memory problems, and it was hard to awaken with Seroquel XR. The current medications were listed as Adderall 30 mg q.i.d. (which was inconsistent with the prior note on November 29, 2013, which indicated Adderall 20 mg q.i.d.), Xanax 4 mg q.i.d., Viibryd 40 mg with a notation of "off," and Seroquel XR 400 mg q.h.s. – still taking p.r.n. The assessment was Panic Disorder (300.21) "stable on Xanax," ADHD "Inattentive Type" (314.00) "stable," Major Depressive Disorder (296.32) "stable," and Insomnia (327.02) "broken sleep." Respondent's treatment plan was refill Xanax and Adderall, add Halcion[15] 0.125 mg – 0.25 mg q.h.s. p.r.n. sleep, Seroquel XR 400 mg q.h.s. p.r.n. sleep, and return to clinic in one month.

68. On or about April 11, 2013, patient R.MA. had a follow up visit with respondent who documented, among other things, that the patient indicated "I'm alive," there was still conflict with his father, and he had an upcoming trial in approximately two weeks for "possession of a firearm [and] discharge in a negligent manner." The current medications were listed as Adderall 30 mg q.i.d. (120 mg per day) and Xanax 4 mg q.i.d. The assessment was Panic Disorder (300.21) "stable," ADHD "Inattentive Type" (314.00) "stable," Major Depressive Disorder (296.32) "in remission," and Insomnia (327.02) "broken sleep." Respondent's treatment plan was add Sonata 10 mg q.h.s. p.r.n. sleep, and return to clinic in 4-6 weeks.

69. A review of patient R.MA.'s CURES report for the period of November 1, 2011, to November 12, 2014, contained indications of patient R.MA.'s misuse, abuse and/or diversion of controlled substances including, but not limited to, large quantities of Xanax (alprazolam)[16] being

[15] Halcion® (triazolam), a benzodiazepine, is a centrally acting hypnotic-sedative benzodiazepine that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short term treatment of insomnia. Concomitant use of Halcion® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Halcion®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[16] As an example, respondent was asked during his HQIU investigatory interview, whether he was aware that between November 25, 2011, through December 31, 2011, patient R.MA. had approximately 5522 mg of Xanax dispensed to him that he got from approximately 12 different pharmacies which amounted to approximately 26-28 mg of Xanax per day. Respondent indicated he was not aware that patient R.MA. had received so much Xanax and had he been aware it would have raised a "red flag" about patient R.MA. "hav[ing] an addiction problem possibly." (Interview Transcript, at pp. 28-31.)

(continued...)

filled over short periods of time by different pharmacies; and patient R.MA. filling prescriptions for opiates[17] that were prescribed by different physicians while respondent was prescribing controlled substances to patient R.MA. During his interview before a Department of Consumer Affairs, Health Quality Unit (HQIU) Investigator and Medical Consultant, respondent admitted that he was not reviewing CURES while he was prescribing controlled substances to patient R.MA. and, thus, was not aware of the prescribing pattern set forth in the CURES report.

70. Respondent committed gross negligence in his care and treatment of patient R.MA. including, but not limited to, the following:

(a) Respondent repeatedly prescribed controlled substances to patient R.MA., including hypnotic sedatives, benzodiazepines and/or amphetamines, to a known substance abuser without any objective and/or justifiable basis for prescribing such amounts of controlled substances;

(b) Respondent repeatedly prescribed controlled substances to patient R.MA. despite indications of abuse and/or addiction to the controlled substances that were being prescribed; and

(c) Respondent repeatedly prescribed controlled substances to patient R.MA. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or without utilizing other risk screening tools

PATIENT R.R.

71. On or about March 30, 2007,[18] respondent had his initial visit with patient R.R. a then thirty-two year old female who was referred to him by a mental health clinic. According to the intake documents, the patient used to take Adderall for ADHD but insurance would not cover the

(...continued)

[17] There are risks associated with the concomitant use of Xanax and opiates which can result in profound sedation, respiratory depression, coma and death.

[18] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

medication, she has anxiety and panic attacks, and that she was clean and sober for the past seventeen (17) months from methamphetamine. Respondent did not order any toxicology testing to confirm that respondent was, in fact, clean and sober for any illicit drugs or controlled substances. No prior medical records were requested or reviewed nor is there any record of respondent making any effort to consult with any prior treating physicians or other health care professionals. Prior psychotropic medications were reported for this initial visit, but there was no documented current or past prescribers or history of mental health illnesses. The Axis I assessment (diagnoses) were ADHD, "combined type" (314.01) and Panic Disorder (Agoraphobia) (300.21). Respondent's treatment plan was to prescribed Valium 10 mg b.i.d. to t.i.d. "to target panic D/O (disorder)," Adderall XR 10 mg q.a.m. "to target ADHD" and Wellbutrin XL 150 mg q.a.m. for seven days and then increase to 300 mg q.a.m.

72. During the period of or about March 30, 2007, to on or about March 24, 2009, patient R.R. had near monthly visits with respondent, except for those visits that she failed to show up for or those visits that were rescheduled. On July 12, 2007, respondent referenced patient R.R.'s prior history of abusing "Crystal Meth" in the "Risk Assessment" section of a United Behavioral Health Outpatient Treatment Progress Report form. During the period March 30, 2007, to on or about March 24, 2009, patient R.R.'s primary Axis I diagnoses were documented as ADHD (314.01), Panic Disorder (Agoraphobia) (300.21), Bipolar Disorder NOS [not otherwise specified] (296.80) [first documented on or about July 23, 2008] and Premenstrual Dysphoric Disorder [first documented on August 23, 2007]. Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg b.i.d, Valium 10 mg b.i.d. to t.i.d., Wellbutrin XL q.a.m. between 150 mg to 450 mg, and other periodic controlled substances and/or dangerous drugs including, but not limited to, Pexeva 30 mg q.a.m., Dexedrine (dextroamphetamine sulfate)[19] 15 mg b.i.d. [increased to 30 mg on November 12, 2008], Abilify

[19] Dexedrine® (dextroamphetamine sulfate) is a central nervous system stimulant of the amphetamine class. Dexedrine® is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of attention-deficit hyperactivity disorder and narcolepsy. The DEA has identified amphetamines, such as Dexedrine®, as drugs of abuse. (Drugs of Abuse, A DEA Resource (continued...)

(antidepressant) 10 mg q.h.s.. The progress note for July 26, 2007, indicates that patient R.R. "ran out of Valium." On April 3, 2008, patient R.R. was instructed to discontinue Adderall (which she did not do) as documented on the progress note for May 1, 2008, indicating "[d]id not stop Adderall as ordered."

73. During the period of on or about April 29, 2009, to on or December 31, 2009, patient R.R. had near monthly visits with respondent, except for those visits that she failed to show up for or those that were cancelled. During this period of time, her primary Axis I diagnoses were documented as Bipolar Disorder NOS [not otherwise specified] (296.80), ADHD "combined type" (314.01), Panic Disorder (Agoraphobia) (300.21), Social Phobia (300.23) [added as a diagnosis on May 27, 2009] and Premenstrual Dysphoric Disorder. Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, and other periodic controlled substances and/or dangerous drugs including, but not limited to, Abilify 10 mg q.h.s. [discontinued in early December 2009, due to "sedation"], Wellbutrin XL 150 mg q.a.m. [added on September 16, 2009], and Dexedrine SR 30 mg b.i.d. [added on October 14, 2009].

74. During the period of on or about January 1, 2010, to December 31, 2010, patient R.R. had near monthly or bimonthly visits with respondent, except for those visits that she failed to show up for or those that were cancelled. During this period of time her primary Axis I diagnoses were documented as Bipolar Disorder NOS [not otherwise specified] (296.80), ADHD "combined type" (314.01), Panic Disorder (Agoraphobia) (300.21), Social Phobia (300.23), and Premenstrual Dysphoric Disorder. Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, Dexedrine 30 mg b.i.d.,

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(...continued)
Guide (2011 Edition), at pp. 42-44.) The Federal Drug Administration has issued a black box warning for amphetamines which provides that "Amphetamines have a high potential for abuse. Administration of amphetamines for prolonged periods of time may lead to drug dependence and must be avoided. Particular attention should be paid to the possibility of subjects obtaining amphetamines for non-therapeutic use of distribution to others, and the drugs should be prescribed or dispensed sparingly. [¶] Misuse of amphetamines may cause sudden death and serious cardiovascular adverse events." Dexedrine® and other stimulants are contraindicated for patients with a history of drug abuse.

Wellbutrin XL 150 mg q.a.m., and other periodic controlled substances and/or dangerous drugs including, but not limited to, Lamictal 75-100 mg q.h.s. [added on March 17, 2010].

75. During the period of on or about January 1, 2011, to December 31, 2011, patient R.R. had two visits with respondent on June 14, 2011, and October 25, 2011.[20] The patient's documented "current status" for the two visits was unremarkable and generally benign. During this period of time her primary Axis I diagnoses were documented as Bipolar Disorder NOS [not otherwise specified] (296.80) [until June 14, 2011], ADHD "combined type" (314.01) [until October 25, 2011, when it was changed to ADHD "Inattentive Type" (314.00)], Panic Disorder (Agoraphobia) (300.21) [until June 14, 2011], Social Phobia (300.23) [until June 14, 2011], Premenstrual Dysphoric Disorder [until June 14, 2011] and Major Depressive Disorder (296.32) [added on October 25, 2011]. Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg b.i.d. [increased to 20 mg t.i.d. on October 25, 2011], Dexedrine 30 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, and Lamictal 100 mg q.h.s. [changed to 50 mg b.i.d. on October 25, 2011].

76. During the period of on or about January 1, 2012, to December 31, 2012, patient R.R. had near monthly visits with respondent, except for her those appointments that she failed to show up for or that were cancelled on March 15, October 24 and November 21, 2012. During this period of time her primary Axis I diagnoses were documented as Major Depressive Disorder (296.32) and ADHD "Inattentive Type" (314.00). Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine 30 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, and Lamictal 50 mg b.i.d. [increased to 100 mg b.i.d. on July 31, 2012].

77. During the period of on or about January 1, 2013, to December 31, 2013, patient R.R. had near monthly visits with respondent, except for her those appointments that she failed to show up for or that were cancelled on August 24 and November 20, 2013. On March 27, patient

[20] There was a gap of nearly six and one-half months between the patient's last visit with respondent on December 3, 2010, and her visit on June 14, 2011, during which time respondent continued to prescribe patient R.R. controlled substances. Patient R.R. did not show up for her appointment on January 25, 2011; "could not be seen – insurance not active" on February 10, 2011, was a "late cancellation" on March 31, 2011; did not show up on May 7, 2011; and cancelled "due to work" on November 22, 2011.

R.R. complained that she had "a ton of stress at work" and that she wanted more Valium. On June 19, she reported she was hit by a car while riding her bike. On July 17, she reported she just found out that her daughter had been sexually assaulted in March 2013, and she was accused of being "Loopy" by CPS (Child Protective Services), and further reported that she might lose her house. During 2013, patient R.R.'s primary Axis I diagnoses were documented as Major Depressive Disorder (296.32) and ADHD "Inattentive Type" (314.00). Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine SR 30 mg b.i.d. [changed to 2 tabs 15 mg b.i.d. on December 10, 2013], Valium 10 mg t.i.d. to q.i.d. p.r.n. anxiety [increased to up to 5 tabs a day on March 27, 2013, and then continued at 10 mg q.i.d. beginning on April 24, 2013], and Lamictal 100 mg b.i.d. [increased to 150 mg b.i.d. on April 24, 2013, and to 200 mg b.i.d. on December 10, 2013, an overall increase from 60 mg per day to 120 mg per day].

78. During the period of on or about January 1, 2014, to December 31, 2014, patient R.R. had near monthly or bimonthly visits with respondent. Many of the progress notes during this period of time were cursory, failed to set forth a detailed narrative history and/or were missing information including, but not limited to the assessment (diagnoses) and family history for some of the visits. During 2014, patient R.R.'s primary Axis I diagnoses were documented, for some of the visits, as Major Depressive Disorder (296.32) [which was changed to Bipolar Mood Disorder NOS on July 8, 2014; and then Unspecified Manic Depressive Psychosis (296.80) on October 21, 2014] and ADHD (314.00). Respondent's treatment plan during this period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine Spansule SR 30 mg 2 tabs b.i.d., Valium 10 mg q.i.d. p.r.n. anxiety, and Lamictal 200 mg b.i.d.

79. During the period of on or about January 1, 2015, to October 13, 2015, patient R.R. had near monthly or bimonthly visits with respondent, with the exception of an approximate four and one-half month gap between the visits of June 16, 2015, and the visit of October 30, 2015. During 2015, patient R.R.'s primary Axis I diagnoses were documented as Unspecified Manic Depressive Psychosis (296.80) and ADHD (314.00). Respondent's treatment plan during this

period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine Spansule SR 15 mg 2 tabs b.i.d., Valium 10 mg q.i.d. p.r.n. anxiety, and Lamictal 200 mg b.i.d.

80. Respondent committed gross negligence in his care and treatment of patient R.R. including, but not limited to, the following:

(a) Respondent repeatedly prescribed excessive doses of hypnotic sedatives, benzodiazepines and/or amphetamines, to a known substance abuser, without any objective and/or justifiable basis for prescribing such amounts of controlled substances; and

(b) Respondent repeatedly prescribed controlled substances to patient R.R. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or without utilizing other risk screening tools.

PATIENT R.P.

81. On or about November 6, 2010, respondent had his initial visit with patient R.P. a then forty-nine year old female who saw respondent for medication management, and who was referred by her therapist B.B., from "A Helping Hand Counseling" center. According to respondent's intake documents, patient R.P. was suffering from Morgellon's disease, a skin disorder, and the patient had suffered a manic episode that "was initiated by a fast titration of an anti-depressant." The past psychiatric history was positive for, among other things, "multiple" episodes over the last two years, with treatment by at least three other physicians, and two inpatient admissions to Mesa Vista Hospital, a psychiatric inpatient facility, for "possible" suicidal ideation. The patient's history was positive for two prior suicide attempts by overdose in September 2010. Patient R.P. indicated, among other things, that during her latest manic episode she was arrested for shoplifting. The patient's current medications were listed as Adderall XR 25 mg t.i.d., Prozac 60 mg q.h.s., Clonazepam 2 mg b.i.d. p.r.n. anxiety, Geodon (generally indicated for the treatment of schizophrenia and/or as monotherapy for the acute treatment of manic or mixed episodes of associated with Bipolar I disorder) 40 mg q.h.s., and Norco (hydrocodone and acetaminophen). Respondent's Axis I diagnosis was Major Depressive Disorder, recurrent,

severe (296.33) with a rule out of Bipolar Disorder NOS. Respondent's treatment plan was to refill Adderall XR 25 mg t.i.d. (with no detailed explanation as to why Adderall was part of the treatment plan for patient R.P.), increase Prozac 20 mg to 80 mg q.h.s., refill Clonazepam 2 mg b.i.d. p.r.n. anxiety, Geodon 40 mg q.h.s., with a notation that the patient needed a primary doctor, "allergy – immunology doctor, and consider a pain specialist."

82. During the period of on or about November 7, 2010, to December 31, 2010, patient R.P. had four additional visits with respondent. On November 22, 2010, respondent noted the patient was "accused of misdemeanor and 2 felonies – burglary/grand theft & carrying a syringe stemming from a visit at a dermatologist..." On December 4, 2010, patient R.P. reported, among other things, difficulty in "getting whole count of Adderall XR" and issues with her seventeen year old son who was addicted to narcotics. On December 20, 2010, patient R.P. reported that her "son may have stolen some of her Klonopin." During the period of on or about November 7, 2010, to December 31, 2010, patient R.P.'s diagnosis was documented as Major Depressive Disorder (296.33). Respondent's treatment plan during this period of time included continuing Adderall XR 25 mg t.i.d. (increased to 30 mg q.i.d. on December 4, 2010), Prozac 80 mg q.h.s., Clonazepam 2 mg b.i.d. p.r.n. anxiety (which appears to have been refilled on November 16, 2010, and then discontinued), Valium 10 mg[21] b.i.d. to q.i.d. p.r.n. anxiety (added on November 17, 2010, and then discontinued on December 4, 2010, due to mediocre to no response), Geodon 40 mg q.h.s. (increased to 60 mg q.h.s. on November 22, 2010) and Klonopin 2 mg b.i.d. p.r.n. anxiety (resumed on December 4, 2014).

83. During the period of on or about January 1, 2011, to December 31, 2011, patient R.P. had near monthly visits with respondent, except for her those appointments that she failed to show up for or that were cancelled on January 22, May 16, June 25, July 16, October 10, October 24, and October 29, 2011. During her office visits of February 28, May 21, and August 1, 2011, patient R.P. discussed her legal problems and impending incarceration for shoplifting and identity

[21] Respondent's medication record indicates that Valium 10 mg was added on November 17, 2010, but there is no associated chart note for that date with an explanation of why the Valium was added as part of the treatment plan in addition to the Clonazepam.

theft for using her sister's personal information. On August 1, 2011, patient R.P. reported that "some Klonopin may be missing." On August 13, October 29 and 31, and November 28, 2011, respondent documented that patient R.P. was being prescribed Percocet[22] (oxycodone and acetaminophen) but there was no documentation as to who was prescribing the Percocet or why it was being prescribed to patient R.P. According to patient R.P.'s CURES report during this time, patient R.P. was receiving opiates (morphine sulfate, oxycodone/acetaminophen (APAP) and/or hydrocodone/APAP) from other physicians during the time that respondent was also prescribing her controlled substances and dangerous drugs. Respondent's Axis I diagnosis (assessment) during this period of time was documented as Major Depressive Disorder (296.33) and ADHD "Inattentive Type" (314.00) [added on February 28, 2011]. Respondents treatment plan during this period of time included continuing with Adderall XR 30 mg q.i.d. (decreased to 25 mg q.i.d. on January 31, 2011), Prozac 80 mg q.h.s., Valium 10 mg q.i.d. p.r.n. anxiety (resumed on January 15, 2011, and discontinued on August 13, 2011), Geodon 60 mg q.h.s. (reduced to 40 mg q.h.s. on January 15, 2011, and discontinued on February 28, 2011), Klonopin 2 mg b.i.d. p.r.n. anxiety (discontinued on January 15, 2011; resumed on April 16, 2011; increased to 2 mg q.i.d. on July 18, 2011; discontinued on August 1, 2011, and resumed on August 13, 2011), Ambilify 5mg q.a.m. (added on August 1, 2011; increased to 10 mg q.a.m. on August 13, 2011) and Buspar (buspirone hydrochloride)[23] 15 mg b.i.d. (tried for one month beginning on July 18, 2011, and then discontinued).

84. During the period of on or about January 1, 2012, to October 26, 2012, patient R.P. had near monthly visits with respondent, except for her appointment that she failed to show up for

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[22] Percocet® (oxycodone and acetaminophen), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

[23] Buspar® (buspirone hydrochloride) is indicated for the management of anxiety disorders or the short term relief of the symptoms of anxiety.

or that was cancelled on February 18, 2012. During this period of time, patient R.P. reported continuing issues with her son who was a heroin addict, the loss of her home, and that she "has to go to court for another shoplifting charge." During this period of time, there were other indications of misuse, abuse and/or diversion of controlled substances including, but not limited to, patient R.P.'s multiple requests for specific dangerous drugs and controlled substances,[24] a medication log entry for January 16, 2012, indicating that "Klonopin filled early...," a report on June 25, 2012, that her son "tried to steal meds from her husband," a report on July 21, 2012, that she "ran out of Abilify/Prozac 6 days ago," a medication log entry of August 27, 2012, indicating "Adderall Script Stolen,"[25] her report of August 18, 2012, that she "doubled her dosage of Adderall which worked well" and a medication log entry of October 15, 2012, indicating "Lost Adderall – Rf (refill) Adderall 20 mg (#120) 1 tab PO (orally) q.i.d." Moreover, the CURES report for patient R.P. indicates that she continued to receive opiates (morphine sulfate, Oxycontin, and/or oxycodone/APAP) from other physicians during the same time that respondent was prescribing her controlled substances and dangerous drugs. Respondent's Axis I diagnosis (assessment) during this period of time was documented as Major Depressive Disorder (296.33) and ADHD "Inattentive Type" (314.00). Respondents treatment plan during this period of time included continuing with Adderall XR 30 mg q.i.d. (discontinued on May 12, 2012; and resumed and changed from Adderall XR 25 to Adderall XR 30 mg q.i.d. with an addition of Adderall 5 mg b.i.d.; and changed again to Adderall 20 mg q.i.d. on August 18, 2012), Xanax 2 mg b.i.d. (added on April 7, 2012), Prozac 80 mg q.h.s., Klonopin 2 mg b.i.d. p.r.n. anxiety (discontinued on April 7, 2012), and periodic prescriptions and adjustments of Abilify and Concerta.

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[24] As an example, patient R.P. reported she "does not like current Adderall XR dosage" on January 21, 2012, she reported "Ritalin was not strong enough" on December 6, 2012, she "want[ed] back on Adderall [-] Prefers it over the Ritalin...," on March 10, 2012, and she "asked for Xanax over Klonopin" on April 7, 2012.

[25] During his interview with an HQIU investigation and Medical Consultant, respondent could not recall whether he asked patient R.P. if she ever filed a police report for the Adderall that she claimed was stolen and he never requested a urine drug screen to determine whether the patient was potentially diverting the Adderall. The FDA's box warning provides that "Amphetamines have a high potential for abuse. Administration of amphetamines for prolonged periods of time may lead to drug dependence. Pay particular attention to the possibility of subjects obtaining amphetamines for non-therapeutic use or distribution to others and the should be prescribed or dispensed sparingly..."

85. On or about October 26, 2012, patient R.P. was discharged as a patient at A Helping Hand Counseling and as a patient of respondent, listed as the Medical Director. The discharge letter provided, in pertinent part:

> "Our records show that you have not been compliant with your treatment regime[n]. On more than one occasion, you have requested medication refills when you should have had medication remaining. [¶] Your records and your account have been reviewed and, as of today, you are not welcome as a patient of A Helping Hand Counseling or Dr. Paniccia from this date forward.
>
> ". . . ."

86. Respondent committed gross negligence in his care and treatment of patient R.R. including, but not limited to, the following:

(a) Respondent repeatedly prescribed excessive amounts of hypnotic sedatives, benzodiazepines and/or amphetamines without any objective and/or justifiable basis for prescribing such amounts of controlled substances; and

(b) Respondent repeatedly prescribed controlled substances to patient R.P. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or without utilizing other risk screening tools.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

87. Respond is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients R.M., K.L.C., R.MA., R.R. and R.P., as more particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

88. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code, in that he repeatedly prescribed clearly

excessive amounts of controlled substances to patients R.M., K.L.C., R.MA., R.R. and R.P., as more particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without An Appropriate Examination and Medical Indication)

89. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he repeatedly prescribed various controlled substances to patients R.M., K.L.C., R.MA., R.R. and R.P., without performing an appropriate prior examination and medical indication, as more particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Furnishing Drugs To Addict)

90. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2241 of the Code, in that he prescribed controlled substances and dangerous drugs to patients R.M., R.MA., R.R. and R.P. whom he knew or reasonably should have known was an addict and/or was using or would be using the controlled substances and dangerous drugs for a nonmedical purpose, as more particularly alleged in paragraphs 11 through 28, 53 through 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

91. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding her care and treatment of patients R.M., K.L.C., R.MA., R.R. and R.P., as more particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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DISCIPLINARY CONSIDERATIONS

92. To determine the degree of discipline, if any, to be imposed on respondent, complainant alleges that an Accusation was filed against respondent on or about September 16, 2002, in a prior disciplinary action entitled *In the Matter of the Accusation against: Gregory S. Paniccia, M.D.*, Medical Board of California Case No. 10-2001-128852. The aforementioned Accusation alleged that respondent engaged in unprofessional conduct when he improperly prescribed excessive amounts of controlled substances to one patient. On August 25, 2003, respondent's medical license was revoked, the revocation was stayed, and respondent was placed on probation for two (2) years probation, on various terms and conditions, including successful completion of a prescribing course, successful completion of a record keeping course, performance of an additional forty (40) hours of continuing medical education (CME) for each year of probation, a partial restriction on his ability to prescribe controlled substances which prohibited him from prescribing Schedule II, III & IV controlled substances during the length of his probation, a prohibition against practicing pain management medicine, and other standard terms and conditions of probation. That decision is now final and is incorporated by reference as if fully set forth herein.

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 No. G76979, issued to respondent Gregory Sean Paniccia, M.D.;

2. Revoking, suspending or denying approval of respondent Gregory Sean Paniccia, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code and advanced nurse practitioners.

3. Ordering respondent Gregory Sean Paniccia, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Taking action as authorized by section 822 of the Code as the Board, in its discretion, deems necessary and proper; and

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

DATED: May 1, 2017

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

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