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

In the Matter of the Accusation Against:	)	
	)	
Matthew Sinclair Stubblefield, M.D.	)	Case No. 800-2016-019765
Physician's and Surgeon's	)	
Certificate No. G 72442	)	
	)	
Petitioner	)	
	)	
	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Michael A. Firestone, Esq., attorney for Matthew Sinclair Stubblefield, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on November 19, 2018.

IT IS SO ORDERED: November 16, 2018

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against:	)	
	)	MBC No. 800-2016-019765
Matthew Sinclair Stubblefield, M.D.	)	
	)	
Physician's and Surgeon's Certificate No. G 72442	)	**ORDER GRANTING STAY**
	)	(Government Code Section 11521)
	)	
Respondent	)	

Michael A. Firestone, Esq. on behalf of respondent, Matthew Sinclair Stubblefield, M.D., has filed a Petition for Reconsideration of the Decision in this matter with an effective date of November 9, 2018, at 5:00 p.m.

Execution is stayed until November 19, 2018, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: November 8, 2018

Kimberly Kirchmeyer
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against:	)	
Matthew Sinclair Stubblefield, M.D.	)	**Case No. 800-2016-019765**
Physician's and Surgeon's Certificate No. G 72442	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 9, 2018.

IT IS SO ORDERED: October 10, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against: MATTHEW SINCLAIR STUBBLEFIELD, M.D., Physician's and Surgeon's Certificate No. G 72442 Respondent.	Case No. 800-2016-019765 OAH No. 2018031006

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on July 16 through 20, 2018, in Oakland, California.

Deputy Attorney General Greg W. Chambers represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).

Attorneys Marvin H. Firestone and Michael Firestone represented respondent Matthew Sinclair Stubblefield, M.D., who was present for the hearing.

The matter was submitted for decision on July 20, 2018.

FACTUAL FINDINGS

1. Respondent Matthew Sinclair Stubblefield, M.D., first received Physician's and Surgeon's Certificate No. G 72442 on September 10, 1991. At the time of the hearing in this matter, this certificate was active, and was scheduled to expire on December 31, 2018.

2. Effective November 20, 2015, the Board placed respondent's certificate on probation for two years. The Board took this action because respondent had prescribed medications to a patient without conducting proper examinations and without monitoring the patient's medication use prudently. As conditions of his probation, the Board required respondent to take a prescribing practices course and a medical record keeping course, and to

have a practice monitor conduct quarterly reviews of his patient records. Respondent completed this probation in November 2017.

3. On January 3, 2018, acting in her official capacity as Executive Director of the Board, complainant Kimberly Kirchmeyer filed a new accusation against respondent. Complainant alleges that respondent has violated laws and regulations governing the practice of medicine by prescribing dangerous drugs, some of which were controlled substances, to three patients without conducting proper examinations and without monitoring these patients' medication use prudently. Complainant seeks revocation of Physician's and Surgeon's Certificate No. G 72442, or an order placing this certificate on further probation. Respondent timely requested a hearing.

Respondent's Training and Medical Practice

4. Respondent graduated from the University of Pittsburgh School of Medicine in 1990. He then undertook a four-year psychiatric residency at the University of California, Irvine. Respondent has sought board certification in psychiatry, but has taken the examination three times unsuccessfully.

5. Respondent is in solo practice, under the name "Center for Behavioral Health," with offices in Palo Alto and Santa Rosa. Respondent accepts only fee-for-service patients, providing bills they may use to seek reimbursement from their health insurance providers; he does not bill health insurance providers himself. He occasionally collaborates with other clinicians, such as psychotherapists, but not as a routine part of his practice.

6. Respondent's medical practice strongly emphasizes treatment of Attention Deficit Hyperactivity Disorder (ADHD), sometimes called Attention Deficit Disorder (ADD), in adults. He estimates that he treats more than 90 percent of his patients for ADHD. Some patients come to respondent from other physicians' referrals, but many refer themselves to him after learning about him through independent research.

Standards of Care for Psychiatric Treatment With Medications

7. Three psychiatrists offered expert testimony in this matter to explain standards of practice that apply to the patient care at issue.

a. Bruce L. Berg, M.D., has held a California physician's and surgeon's certificate since 1983 and is board-certified in adult psychiatry. Dr. Berg has worked as a general adult psychiatrist since 1988, in community clinic settings for the Veterans Administration and for California State University, Sacramento, as well as in private practice. He has treated adults with ADHD throughout his career.

b. Barton J. Blinder, M.D., Ph.D., is board-certified in adult and child psychiatry and holds a California physician's and surgeon's certificate. He is a professor at the University of California, Irvine, College of Medicine and also at the University of

Washington School of Medicine. Although he considers his major expertise to be in treatment of eating disorders, he also has treated adults with ADHD throughout his career.

c. David W. Goodman, M.D., is a board-certified adult psychiatrist and neurologist. Dr. Goodman is in private clinical practice, and also supervises psychiatry residents at Sinai Hospital in Baltimore through the Johns Hopkins University School of Medicine. Dr. Goodman does not hold a California physician's and surgeon's certificate, but testified persuasively that practice standards for adult psychiatrists are similar throughout urban areas in the United States. Dr. Goodman has published extensively about treating adults with ADHD and treats many such patients in his practice.

8. Drs. Berg and Blinder agreed that a psychiatrist must take a thorough history of the patient's presenting symptoms, including a childhood history, to diagnose psychiatric illness. Childhood history is particularly relevant for diagnosing ADHD, because it is a disorder that is present throughout a person's lifetime even though it may not cause significant functional challenges at every age or in every situation. Moreover, because medications for ADHD are also common drugs of abuse, a psychiatrist must avoid relying solely on a patient's self-report to diagnose ADHD. Dr. Goodman did not address this issue explicitly, but did not disagree with Drs. Berg and Blinder; their opinion is persuasive.

9. Drs. Berg, Blinder, and Goodman agreed that maximum recommended daily medication doses approved by the federal Food and Drug Administration (FDA) reflect statistical average responses from clinical trials involving large study populations. Variation in body composition or metabolism may cause an individual patient to need more medication than the FDA-approved maximum recommended dose to achieve the positive effects the prescriber intends. For this reason, a reasonably prudent physician may prescribe medications in excess of FDA-approved maximum recommended daily doses. This opinion, shared by all expert witnesses, is persuasive.

10. Drs. Berg, Blinder, and Goodman agreed that stimulant medications can have positive therapeutic effects on impulsivity, focus, and cognition in people with ADHD. These experts also agreed that both persons who have ADHD and persons who do not can abuse stimulant medications to achieve pleasurable but nontherapeutic euphoria. Finally, these experts agreed that stimulant medications can have negative physical and psychological effects, such as anxiety or even paranoia, headaches, sleep disturbance, elevated heart rate and blood pressure, and substance use disorder. This opinion, shared by all expert witnesses, is persuasive.

11. Drs. Berg, Blinder, and Goodman agreed that a physician prescribing stimulant medication must monitor his or her patient carefully. The physician may prescribe medication above the minimum dose that shows an effect for the patient, but to avoid unnecessary risk should take care to limit the patient's dose to one above which no additional therapeutic effect is evident. The physician also should pay special attention to signs that the patient is experiencing negative physical or psychological effects from the medication. This opinion, shared by all expert witnesses, is persuasive.

12. Drs. Berg, Blinder and Goodman testified that a physician prescribing any new medication to a patient, but particularly a controlled substance or a drug with addictive potential, must discuss the medication's risks and benefits with the patient. The physician also must discuss, or consider, the patient's previous history with the medication, or with similar medications. This opinion, shared by all expert witnesses, is persuasive.

13. Dr. Berg testified that a psychiatrist should not assume responsibility for a patient's primary medical care without conducting a thorough history and physical examination. More commonly, psychiatrists collaborate with other providers who treat patients' primarily physical health conditions, and in this relationship a psychiatrist must consult the primary care provider to ensure that psychiatric treatment neither duplicates nor conflicts with other treatment. This opinion regarding the standard of psychiatric care is persuasive.

14. Dr. Berg testified that he understands relevant federal laws and regulations to prohibit a physician's communicating with a patient using ordinary mobile telephone text messaging, because of the risk that such communications will permit unauthorized persons to learn the patient's private medical information. Drs. Blinder and Goodman testified that regardless of strict legal requirements, a reasonably prudent physician may use text messaging to communicate minimally with a patient regarding non-clinical matters such as scheduling without unacceptable risk to patient privacy. The evidence did not establish precisely what relevant federal laws and regulations govern text messaging communications between physicians and patients, or whether and under what circumstances such communications do or do not satisfy those laws and regulations.

Patient J.S.

15. Drs. Berg, Blinder, and Goodman reviewed respondent's records regarding J.S. and rendered opinions based on their reviews. In addition, respondent testified regarding his treatment of J.S. Respondent's records for J.S. also included incidental records from other physicians and from laboratories, but no other treating physicians' records otherwise were in evidence. Neither J.S. nor any of his family members testified.

RESPONDENT'S CARE FOR J.S.

16. Respondent first saw patient J.S. on March 24, 2014. J.S. was 30 years old, and had taken the California bar examination in February 2014 (successfully, although he did not know until May 2014 that he had passed). After having lived on the East Coast and in San Diego, J.S. lived with his parents in March 2014, as he awaited his bar results and searched for legal employment.

17. Respondent's records state that J.S. found respondent through an online search. J.S. told respondent that J.S. had "trouble focusing." Respondent noted as well that J.S. described having been treated for ADHD at a college clinic; that he also had received

treatment through the Kaiser Permanente medical organization; and that he was currently under treatment with levothyroxine[1] and Celexa[2] (generic name citalopram).

18. J.S. brought respondent a letter dated February 12, 2014, from a Mark Rodehaver, M.D., and addressed "To Whom it May Concern." The letter states that Dr. Rodehaver treated respondent for ADHD and anxiety for three years, and had prescribed both sustained-release methylphenidate[3] (trade name Ritalin SR) and clonazepam[4] (trade name Klonopin) to J.S.

19. Dr. Rodehaver's most recent prescription to J.S. for Ritalin SR was on August 29, 2013, for 120 20-milligram capsules to be taken as two capsules (40 milligrams) each morning and two more each evening. Dr. Rodehaver's letter states that J.S. had "been responding" to this dose, and "strongly" recommends continuing this drug. The evidence established that 80 milligrams of methylphenidate per day is an above-average daily dose.

20. Dr. Rodehaver's letter states that he had prescribed one milligram of clonazepam as needed, but no more often than four times per day, to J.S. The letter cautions that J.S. experienced "challenge in terms of staying within that limit" during periods of high stress. The letter states that Dr. Rodehaver "would support limited doses of a benzodiazepine combined with cognitive behavioral therapy" as ongoing treatment for J.S.'s anxiety.

21. The evidence did not establish that respondent ever asked J.S. to authorize Dr. Rodehaver to provide further information to respondent. The evidence did not establish that respondent ever contacted Dr. Rodehaver to discuss J.S. with him, or to obtain copies of Dr. Rodehaver's treatment records regarding J.S.

22. The evidence did not establish that respondent ever asked J.S. to authorize Kaiser Permanente to provide information to respondent about J.S.'s health care. The evidence did not establish that respondent contacted any Kaiser Permanente physician at the beginning of J.S.'s treatment to discuss J.S., or to obtain copies of treatment records regarding J.S.

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[1] Levothyroxine is a drug that replaces thyroid hormone when natural production is insufficient. Under the definition in Business and Professions Code section 4022, it is a dangerous drug. All further references to a "dangerous drug" are to this statutory definition.

[2] Citalopram or Celexa is an antidepressant medication. It is a dangerous drug.

[3] Methylphenidate or Ritalin is a central nervous system stimulant. It is a dangerous drug and a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(6).

[4] Clonazepam or Klonopin is a benzodiazepine anti-anxiety drug. It is a dangerous drug and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(7).

23. In particular, despite J.S.'s report at his first visit on March 24, 2014, that he was currently taking Celexa, an antidepressant medication, the evidence did not establish that respondent made any effort to discuss J.S.'s mental health care with anyone who had provided such care in the weeks or months immediately before J.S.'s first visit with respondent. Moreover, the evidence did not establish that respondent ever attempted to determine why J.S. had come to respondent only for treatment of his "trouble focusing" rather than either seeking such treatment from the person who had prescribed Celexa to him or seeking comprehensive mental health treatment from respondent. Finally, the evidence did not establish that respondent made any effort—at the initiation of treatment or at any time thereafter—to coordinate respondent's care of J.S. with any other physician or psychotherapist who treated J.S. concurrently for mental or physical health problems.

24. On February 6, 2014, at a Kaiser Permanente pharmacy, J.S. had filled a prescription from Matthew Eisley, M.D., for 60 5-milligram methylphenidate tablets. Respondent's notes do not list any form of methylphenidate among J.S.'s current medications. They also do not indicate that respondent asked J.S. how he had managed studying for and taking the California bar examination without this medication, despite having used it steadily and in apparently significant doses during law school (as stated above in Findings 16 through 19).

25. At J.S.'s first visit, respondent gave J.S. a laboratory order for urine and blood testing, including a screen for drugs of abuse. The evidence did not establish that respondent ever obtained results from any such test for J.S.

26. J.S. completed a patient intake questionnaire, and several checklists stating in their titles that they sought information about "ADD" symptoms, at his first visit to respondent. Respondent performed no other diagnostic evaluations and obtained no prior medical or educational records. His stated plan at J.S.'s first visit was to "rule out" several diagnoses (including ADHD, a mood disorder, and a substance use disorder); but the evidence did not establish any specific steps respondent ever took to diagnose or to rule out any such disorders.

27. On March 24, J.S. filled a prescription from respondent for 10 30-milligram and 10 50-milligram capsules of Vyvanse.[5] Although this medication generally aligns with Dr. Rodehaver's prior treatment of J.S. for ADHD, respondent's notes do not explain why he recommended that J.S. switch from methylphenidate to Vyvanse.

28. Respondent's records regarding J.S. include a written "Patient Informed Consent for Psychostimulant Medications" bearing J.S.'s apparent signature, and the date "3/24/14." The document states several principles to which the patient must agree, including not taking medication in a different amount or frequency than prescribed; obtaining

[5] Vyvanse, or lixdexamfetamine, is a central nervous system stimulant. It is a dangerous drug and a Schedule II controlled substance under Health and Safety Code section 11055, subdivisions (d)(1) and (f).

medication from respondent only; not requesting early refills; not hoarding or giving away medication; and returning any unused medication to respondent.

29. The evidence did not establish that respondent ever discussed with J.S. any potential risks of stimulant medication beyond the risks described in the "Patient Informed Consent for Psychostimulant Medications." In particular, the evidence did not establish that respondent advised J.S. that J.S. ever had been, or might be, on daily stimulant doses above those in common use. Similarly, the evidence did not establish that respondent ever discussed the possibility that J.S. might abuse his stimulant medication, or that the medication could cause J.S. to experience inappropriate and excessive anxiety.

30. J.S. returned to see respondent on April 8. Respondent's notes state that J.S. had taken 30 milligrams of Vyvanse each day for 10 days, and 50 milligrams each day for four days. If this report were true, J.S. still would have had six 50-milligram Vyvanse capsules; but respondent's notes do not reflect that respondent asked J.S. to return these capsules. On April 8, J.S. filled a prescription from respondent for 30 30-milligram Vyvanse capsules.

31. On April 8, J.S. also received a prescription from Michael Sands, M.D., a Kaiser Permanente physician, for 200 10-milligram Ritalin SR tablets. The evidence did not establish that J.S. filled this prescription. Respondent's notes from J.S.'s April 8 visit state that J.S. told respondent about this prescription, and said that he would not fill it. The evidence did not establish that respondent made any effort to follow up this information by speaking with Dr. Sands about J.S.'s treatment.

32. J.S. returned to see respondent on April 23 and May 7. At each visit, respondent increased J.S.'s daily Vyvanse dose, and prescribed additional capsules. Respondent's prescriptions during this period, all of which J.S. filled, gave J.S. enough Vyvanse capsules to last until late June if J.S. had taken the medication as respondent had prescribed. In addition, on May 7 respondent prescribed, and J.S. obtained, 30 10-milligram mixed amphetamine salts[6] tablets. Respondent prescribed the mixed amphetamine salts as an afternoon stimulant "booster," because J.S. complained that he stopped feeling a benefit from the Vyvanse in the mid-afternoon.

33. J.S.'s office visit on May 7, 2014, was the first time respondent's notes include any record of J.S.'s blood pressure. It was not high.

34. On May 15, 2014, J.S. filled a prescription from a Kaiser Permanente physician for 90 60-milligram Vyvanse capsules. Respondent did not learn that J.S. had received or filled this prescription until October 2014, as described below in Finding 48.

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[6] Mixed amphetamine salts, of which Adderall is a trade name, is a central nervous system stimulant. It is a dangerous drug, and is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1).

35. Respondent's notes show that J.S. called respondent on June 18, 2014, for an emergency medication refill. J.S. filled a prescription from respondent on that day for two 50-milligram Vyvanse capsules and two 10-milligram mixed amphetamine salts tablets.

36. The next day, June 19, J.S. returned to respondent's office. Despite the matters stated in Findings 32 and 35, respondent's notes reflect no discussion of what medications, in what doses, J.S. had taken between May 7 and June 18. J.S. reported to respondent on June 19 that 50 milligrams of Vyvanse per day is "working well" but "wears off early."

37. Respondent's notes from J.S.'s June 19 visit state that respondent intended to increase J.S.'s daily Vyvanse dose to 70 milligrams, and that J.S. should return in two weeks. Yet on June 19, J.S. filled a prescription from respondent for 30 70-milligram Vyvanse capsules, which would have been a 30-day supply as prescribed. J.S. also filled a prescription from respondent on this date for 45 10-milligram mixed amphetamine salts tablets.

38. J.S. visited respondent three times during July 2014 (July 2, July 16, and July 29). After each visit, J.S. filled prescriptions from respondent for both Vyvanse and mixed amphetamine salts. On July 2, respondent prescribed 100 milligrams of Vyvanse per day; on July 16, respondent prescribed 120 milligrams of Vyvanse per day; and on July 29 respondent prescribed 140 milligrams of Vyvanse per day. In addition, on each of these occasions respondent prescribed mixed amphetamine salts for the afternoons.

39. On July 2 and July 16, the numbers of capsules and tablets in respondent's prescriptions matched respondent's notes as to how much of each medication respondent expected J.S. to consume each day. On July 29, however, J.S. filled one prescription from respondent for 30 70-milligram Vyvanse capsules (enough to take two capsules per day for 15 days) as well as one for 15 50-milligram Vyvanse capsules. Respondent's notes do not explain this discrepancy.

40. On July 2, J.S. reported to respondent that J.S. had lost some of his medication. Respondent's notes state that he agreed to "excuse only once," and that his July 2 prescription represented an "early" refill. The notes include no explanation of respondent's decision to increase J.S.'s prescribed Vyvanse dose from 70 milligrams per day to 100 milligrams per day, however.

41. Throughout this period, respondent's notes regarding J.S.'s psychological functioning are cursory. They report that J.S. describes stimulant medication as making him more "productive," but they include no detail that might have helped respondent distinguish real accomplishments from overstimulated busy work. Furthermore, they do not show that respondent ever suggested or referred J.S. to other providers for help with non-drug methods to manage fluctuations in mood, focus, or motivation.

42. J.S.'s next appointment was on August 11, 2014. Respondent's notes again indicate that J.S. reported good effects, in this case from 140 milligrams of Vyvanse each morning. For reasons his notes do not explain, however, respondent recommended that J.S. eliminate the afternoon "booster" dose of mixed amphetamine salts and instead take a second 140-milligram dose of Vyvanse in the evening.

43. Respondent saw J.S. again two weeks later, on August 25, 2014. Because J.S. reported some difficulty falling asleep, respondent recommended that J.S. reduce his intake of Vyvanse to 120 milligrams twice per day for "a few days, then" to 130 milligrams twice per day.

44. Respondent's medical notes show that he checked J.S.'s blood pressure on August 11, 2014, and again on August 25, and that it was not high on either date.

45. At J.S.'s next appointment, on September 9, 2014, he reported that he preferred taking 240 milligrams of Vyvanse daily rather than 260 milligrams. Respondent continued this prescription, and directed J.S. to return in about one month.

46. J.S. returned on October 6, 2014. Respondent noted J.S.'s report that his stimulant dose was "good," and that he had recently begun an internship in a local government law office. Respondent asked J.S. to return in two months.

47. Respondent's records include correspondence he received at his office in the evening on October 20, 2014, from Dr. Sands at Kaiser Permanente, transmitting J.S.'s consent for respondent to speak with Dr. Sands about J.S.'s care. According to respondent's notes, he spoke with Dr. Sands on October 22, and learned that J.S. had told Dr. Sands that he wanted Dr. Sands to assume responsibility for his ADHD medication, to save money. Respondent noted that Dr. Sands was willing to prescribe at the same doses respondent had been prescribing, as long as Dr. Sands saw respondent regularly.

48. For the first time in his relationship with J.S., respondent requested a report from the Controlled Substance Utilization Review and Evaluation System (CURES). He learned from that report that J.S. also had obtained Vyvanse on Dr. Sands's prescription in May, as described above in Finding 34. The evidence did not establish that respondent ever discussed this matter with J.S.

49. Despite his conversation with Dr. Sands, respondent continued between October 20 and December 4 prescribing stimulant medication for J.S., in quantities sufficient to permit J.S. to take four 60-milligram capsules per day into January 2015. Respondent's records include no notes regarding any in-person visits with J.S. between October 20, 2014, and March 12, 2015.

50. On December 23, 2014, J.S. obtained 60 60-milligram Vyvanse capsules, prescribed by Dr. Sands. Less than two weeks later, on January 5, 2015, again on Dr. Sands's prescription, J.S. obtained 200 60-milligram Vyvanse capsules. Finally, on

February 28, 2015, upon prescription from Alex Dimitriu, M.D., J.S. received 30 70-milligram Vyvanse capsules.

51. J.S. returned to respondent's office on March 12, 2015. He stated that he believed that 240 milligrams of Vyvanse per day was too much, because it affected his sleep "a little bit." Respondent recommended that J.S. return to 100 milligrams per day each morning, and that he resume taking mixed amphetamine salts in the afternoon. Respondent prescribed, and J.S. obtained, 15 30-milligram Vyvanse capsules, which respondent believed J.S. could combine with his remaining 70-milligram capsules over the next 15 days to total 100 milligrams per day. Respondent also prescribed, and J.S. obtained, 15 20-milligram mixed amphetamine salts tablets.

52. Respondent obtained a second CURES report regarding J.S. on March 12, 2015. This report revealed the matters stated in Findings 49 and 50, above, and should have alerted respondent that J.S. had obtained Vyvanse capsules by prescription in quantities that would have permitted J.S. to consume significantly more than 240 milligrams of Vyvanse per day between October 20, 2014, and March 12, 2015. The evidence did not establish that respondent ever recognized that J.S. had received these excessive quantities of stimulant medication, or that he ever asked J.S. what J.S. actually had done with the medication.

53. J.S. returned to respondent on March 23, April 14, April 28, and May 19. At each visit, respondent prescribed the same stimulant regimen: 100 milligrams of Vyvanse and 20 milligrams of mixed amphetamine salts per day.

54. Respondent's notes are sparse regarding J.S.'s psychological function during this period. In particular, the notes reflect an ongoing search for employment, indicating that the October 2014 internship did not result in a permanent position; but they reflect no effort by respondent to learn why J.S. was experiencing such difficulty or whether mis- or over-medication might have been a contributing factor.

55. Aside from their single October 2014 conversation, the evidence did not establish that respondent ever again conferred with Dr. Sands regarding J.S.'s care.

56. At J.S.'s April 14, visit, respondent began prescribing citalopram to J.S. At J.S.'s May 19 visit, respondent began prescribing buspirone[7] for "depression/anxiety." The evidence did not establish that respondent consulted with any other provider before beginning to prescribe citalopram (which J.S. previously had obtained elsewhere) or before adding buspirone; the evidence also did not establish that respondent considered, or recommended to J.S., any non-drug methods of addressing J.S.'s concerns, such as psychotherapy or career counseling.

57. During summer 2015, J.S.'s stimulant consumption gradually escalated again. After J.S. reported that he often wanted to nap in the early afternoon, respondent

[7] Buspirone is an anti-anxiety medication. It is a dangerous drug.

recommended a second 20-milligram mixed amphetamine salts tablet each day. On June 30, J.S. reported that someone had stolen his Vyvanse; respondent prescribed replacement medication, writing that J.S. "knows I will not do this again."[8] On July 15 J.S. obtained another 30-day supply of Vyvanse at 100 milligrams per day; but on July 24 he obtained an additional 30-day supply of Vyvanse, this time at 120 milligrams per day. In August, respondent raised J.S.'s dose of mixed amphetamine salts to two 30-milligram tablets per day. In September, respondent recommended adding 10 milligrams of mixed amphetamine salts to a daily morning dose of 110 milligrams of Vyvanse; respondent raised the daily Vyvanse dose back to 120 milligrams in October.

58. In November and December 2015 and in January 2016, J.S. saw respondent biweekly. He complained of increasing family tension and personal stress, and respondent increased his citalopram dose. Respondent also recommended that J.S. consult a psychotherapist, but J.S. did not do so. Respondent's notes do not reflect a recommendation to change J.S.'s Vyvanse dose, but J.S.'s prescription records for this period do not match the dosage recommendations in respondent's notes.

59. Also in November 2015, J.S.'s father called respondent several times in an effort to discuss J.S.'s care. Respondent's notes state that J.S.'s father described J.S. as "addictive," "non-productive," and "argumentative," and expressed his concern that J.S. was abusing stimulant medication. Respondent discussed the calls with J.S. but did not press J.S. for permission to speak with J.S.'s father. Respondent did not return J.S.'s father's calls.

60. On November 11, 2015, respondent recorded J.S.'s blood pressure for the first time since August 25, 2014. It was not high.

61. On December 30, 2015, J.S. complained of increasing anxiety, and respondent prescribed clonazepam. He told J.S. to take one 1-milligram tablet per day, and prescribed 15 tablets. When respondent returned on January 5, 2016, respondent recommended that J.S. increase his clonazepam consumption to three 1-milligram tablets per day, and prescribed 90 tablets. On that date, respondent also prescribed additional Vyvanse capsules to replace medication that J.S. reported again that he had lost. Finally, respondent prescribed additional mixed amphetamine salts tablets, this time as 25-milligram tablets.

62. J.S. obtained the Vyvanse and clonazepam as respondent had prescribed on January 5. He discovered, however, that mixed amphetamine salts did not come in 25-milligram tablets. On January 16, 2016 (a Saturday), J.S. decided that he urgently needed to obtain additional mixed amphetamine salts. He exchanged ordinary mobile telephone text messages with respondent, and arranged to drive from the Fremont area to Santa Rosa (about 75 miles each way) to have respondent give him a replacement prescription for 20-milligram tablets. Respondent agreed to do so without consulting J.S.'s medical records (which respondent kept at his Palo Alto office), and J.S. filled this replacement prescription for 60 tablets on January 17.

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[8] J.S. waited until July 2 to fill the prescription.

63. In a complaint to the Board about respondent, J.S.'s father stated that J.S.'s mother had accompanied J.S. to Santa Rosa on January 16, 2016, and had attempted there to speak with respondent but respondent refused. The evidence at the hearing did not establish that any such interaction occurred.

64. On January 29, 2016, J.S. entered a residential substance use disorder treatment program. He spent about a month there, after physicians diagnosed him with severe stimulant use disorder. Despite having received stimulant drugs well in excess of the amounts necessary to take those drugs as respondent had prescribed, J.S. reported at his intake to the substance abuse treatment program that he had "run out" of medication and experienced "withdrawal."

65. In March 2016, after his discharge from the inpatient treatment program, J.S. returned briefly to respondent's care. Respondent's notes state that J.S. wanted to resume using Vyvanse, but that the sober living environment in which he lived would not permit him to do so. Although J.S. admitted to respondent that J.S. had taken medication in excess of respondent's prescriptions; although respondent had access to CURES reports showing that J.S. could have taken excess medication regularly, rather than simply occasionally; and although respondent received full records from the inpatient substance abuse treatment program, respondent's notes express doubt that J.S. ever had abused stimulant drugs.

66. J.S. terminated treatment with respondent in June 2016.

EXPERT OPINIONS REGARDING RESPONDENT'S CARE FOR J.S.

67. Dr. Berg opined that respondent committed extreme departures from the standards of care described in Findings 8 through 11 in treating J.S. In particular:

a. Based on the matters stated in Findings 17 through 26, respondent failed to make an adequate initial assessment of J.S.'s risk for substance abuse, failed to perform a complete psychiatric evaluation, and failed to give adequate consideration to past psychiatric problems or to current comorbid conditions. Respondent took J.S.'s statements at face value, ultimately failing to consult meaningfully with any other clinicians about J.S.'s treatment. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

b. Based on the matters stated in Findings 36 through 42, respondent did not use a careful, methodical titration in prescribing stimulant medication to J.S. Instead, respondent escalated J.S.'s stimulant dose rapidly, without allowing time for J.S. to adjust to it and without monitoring whether increasing doses really improved J.S.'s day-to-day psychological function. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

c. Based on the matters stated in Finding 61, respondent did not use a careful, methodical titration in prescribing clonazepam for J.S. Instead, respondent escalated J.S.'s clonazepam dose rapidly, without allowing time for J.S. to adjust to it and without monitoring whether increasing doses really improved J.S.'s day-to-day psychological function. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

d. Based on the matters stated in Findings 31 through 36, 40, 41, 44, 48 through 50, 52, 54 through 56, 59 through 62, and 65, respondent failed to monitor J.S. adequately for signs that he was suffering harm from his stimulant medication, or that he was misusing it. Respondent did not monitor J.S.'s vital signs regularly, or maintain contact with a primary care physician who did. Respondent obtained no collateral information about J.S.'s medication use, even when J.S.'s father pleaded to speak with respondent about J.S. Respondent obtained CURES reports, but failed to use them carefully. Respondent failed to observe that J.S. deteriorated, rather than improved, under respondent's care. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

68. Based on the matters stated in Findings 32, 35, 36, 39, 40, 42, 49, 51, 57, and 64, Dr. Berg opined that respondent prescribed clearly excessive amounts of stimulant medication to J.S. This opinion is persuasive.

69. Dr. Berg also opined that respondent committed simple departures from the standards of care described in Findings 12 and 14 in treating J.S. In particular:

a. Based on the matters stated in Finding 62, respondent handled J.S.'s confidential medical information carelessly when he exchanged text messages with J.S. regarding a prescription. Due to the matters stated in Finding 14, this opinion was not persuasive.

b. Based on the matters stated in Findings 20, 27 through 29, and 61, respondent prescribed first Vyvanse and later clonazepam to J.S. without documenting full discussion of these drugs' addictive potential, and without documenting consideration of J.S.'s prior experience on those or similar drugs. Dr. Berg's opinion is persuasive that these failures represent simple departures from the care a reasonably prudent physician would have provided under similar circumstances.

70. Based on the matters stated in Findings 15, 23 through 27, 39, 41, 49, and 54, respondent failed to maintain complete, accurate, and adequate records describing his treatment of J.S. Dr. Berg's opinion is persuasive that these records are inadequate.

71. Dr. Blinder opined that the end result of J.S.'s treatment with respondent was "regrettable." He does not believe, however, that respondent's care for J.S. deviated from the standards described in Findings 8 through 14. In light of all the evidence about J.S.,

Dr. Blinder's opinion that J.S.'s course of treatment was "regrettable" is persuasive; his opinion that respondent met the standard of care is not.

72. Dr. Goodman opined that respondent treated J.S. prudently, and in accordance with the standards described in Findings 8 through 14. According to Dr. Goodman, respondent performed an adequate initial assessment of J.S., and monitored J.S.'s response to medication appropriately.[9] Dr. Goodman perceived no evidence of harm to J.S. because of respondent's treatment; he found little evidence in respondent's records to support the conclusion that J.S. abused his stimulant medication, and doubted that J.S. ever needed or benefited from treatment for a substance use disorder. In light of all the evidence about J.S., these opinions are not persuasive.

Patient D.B.

73. Drs. Berg, Blinder, and Goodman reviewed respondent's records regarding D.B. and rendered opinions based on their reviews. In addition, respondent testified regarding his treatment of D.B. Respondent's records for D.B. also included incidental records from psychological testing services and from an imaging study, but no other treating physicians' records were in evidence. D.B. did not testify.

RESPONDENT'S CARE FOR PATIENT D.B.

74. D.B. began treatment with respondent in December 2007. She was 39 years old and worked as a statistical programmer.

75. D.B. told respondent at her initial visit that she had seen six other mental health professionals during the previous 15 years, and had tried a variety of psychotropic medications. She complained to respondent of "trouble focusing, sustaining attention." D.B. came to respondent after learning about him in an "internet chat room," and noted that her "current therapist . . . doesn't believe in ADD."

76. At an early appointment, D.B. described herself as having at one time been "on the verge of being an alcoholic." The evidence did not establish that respondent followed up this discussion with any analysis of D.B.'s alcohol or drug use patterns, or that he took any special steps during his treatment of D.B. to monitor her for substance abuse.

77. Respondent did not obtain records from any of D.B.'s prior mental health providers. He did obtain records from several educational and psychological testing providers D.B. had seen. Some of these records stated or suggested diagnoses of learning disabilities or anxiety; none diagnosed ADHD. A report from a "Psycho Educational

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[9] With respect to J.S., as well as to D.B. and J.A., Dr. Goodman did "agree that a greater vigilance to documentation of target symptoms, side effects, medication, adherence, and vital signs would have better substantiated the stimulant dosing [respondent] prescribed."

Evaluation" by the Morrissey/Compton Educational Center in 2002 stated, "those areas that are often low in individuals with ADD were some of [D.B.'s] strongest skills."

78. At D.B.'s first appointment in December 2007, respondent prescribed Strattera[10] to her. By March 2008, respondent was prescribing 162 milligrams of Strattera per day to D.B. Through late 2010, respondent prescribed Strattera, Adderall, Gabitril,[11] Ativan,[12] Topamax,[13] and Abilify[14] to D.B. Respondent's notes for this period describe D.B.'s self-reported symptoms, but they do not state any psychiatric diagnosis.

79. Respondent's records regarding D.B. indicate that he recorded her blood pressure and heart rate on only four occasions: in March 2008, February 2009, February 2010, and on March 2015.

80. On February 15, 2011, respondent prescribed 120 milligrams of Adderall and 10 milligrams of Abilify per day to D.B. He continued these prescriptions over the next several months during 2011. D.B. reported several times to respondent that she experienced "ghosts," worry, and intrusive negative thoughts; she also reported that she had discontinued and then resumed her medications, or had reduced her dose below what respondent had prescribed. Respondent simply continued D.B.'s medication regimen.

81. In May 2011, respondent referred D.B. for a single-photon emission computerized tomography (SPECT) study of her brain. Respondent's notes do not say why he believed this diagnostic tool would help him, although the referral form states that he wished to rule out "limbic epilepsy" and "fronto-temporal dysfunction." D.B. did not obtain this test until November 2012, and respondent's notes do not reflect that he used it in any way to guide his treatment of D.B.

82. Respondent's records regarding D.B. also include a report from the Connors' Continuous Performance Test II (CPT II), which D.B. also took in November 2012. The report states that the CPT II is "helpful when a diagnosis of ADHD is being considered." According to this report, D.B.'s results would be no more likely to occur in a person with

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[10] Strattera, or atomoxetine, is used in treating ADHD. It is a dangerous drug.

[11] Gabitril, or tiagabine, is an anti-convulsant drug sometimes used as an anti-anxiety medication. It is a dangerous drug.

[12] Ativan, or lorazepam, is a benzodiazepine anti-anxiety drug. It is a dangerous drug and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(16).

[13] Topamax, or topiramate, is used to control pain, and in higher doses as a mood stabilizer. It is a dangerous drug.

[14] Abilify, or aripiprazole, is an anti-psychotic medication. It is a dangerous drug.

ADHD than in a person without ADHD. Respondent's records do not indicate that he used this test result in any way to guide his treatment of D.B.

83. Between June 2011 and June 2013, respondent's notes state that he recommended repeatedly that D.B. take Intuniv.[15] Instead of doing so, D.B. tried various nutritional supplements, and modified her consumption of the other medications respondent had prescribed. The evidence did not establish that D.B. ever took this medication.

84. On August 1, 2012, respondent's notes state that D.B. complained of having lost a prescription for Topamax. Respondent's own prescribing notes do not state that he had prescribed this drug to D.B. in the year before this appointment. Respondent wrote a prescription for this drug to D.B. on this date, although his notes do not state why he believed she would benefit from it. D.B. did not like the drug's effects and did not continue taking it.

85. Respondent's records regarding D.B. include a written "Patient Informed Consent for Psychostimulant Medications" similar to the one described above in Finding 28. It bears D.B.'s apparent signature, and the date "6/17/2013."

86. Respondent continued prescribing Adderall to D.B. between September 25, 2013, and October 13, 2016. He prescribed Strattera on one occasion, because D.B. stated an interest in trying it again; but at her next visit, almost three months later, D.B. reported that she had stopped taking both Adderall and Strattera. She restarted Adderall, however, despite having told respondent that she experienced "less lip-biting" when she was not taking it.

87. On June 8, 2016, respondent obtained a CURES report regarding D.B., covering approximately the previous six months. That report did not indicate that D.B. had filled controlled substance prescriptions from anyone other than respondent. This report is the only such report in D.B.'s record.

88. The evidence did not establish that D.B. ever took more stimulant medication than respondent had prescribed, or that she ever asked respondent to increase her stimulant dose or to prescribe replacement stimulant medication.

89. Throughout the course of her treatment with respondent, and according to respondent's notes, D.B. reported similar mental and physical health complaints, sometimes better and sometimes worse. She never reported significant and lasting subjective feelings of improvement, and she never reported changes in her life circumstances (such as more lucrative or fulfilling employment, or new and rewarding personal relationships) that might have indicated objectively that her psychological function had improved. On the other hand, D.B. also never reported significant and lasting decline in her subjective well-being, or new and more serious problems at work or in her personal relationships that might have indicated objectively that her psychological function had deteriorated.

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[15] Intuniv, or guanfacine, is a drug that can improve attention. It is a dangerous drug.

90. In late 2016, when respondent's records regarding her treatment end, D.B. was not employed. She was living with, and caring for, her elderly mother.

EXPERT OPINIONS REGARDING RESPONDENT'S CARE FOR PATIENT D.B.

91. Dr. Berg opined that respondent committed extreme departures from the standards of care described in Findings 8 through 11 in treating D.B. In particular:

a. Based on the matters stated in Findings 75 through 78, respondent failed to make an adequate initial assessment of D.B.'s risk for substance abuse, failed to perform a complete psychiatric evaluation, and failed to give adequate consideration to past psychiatric problems or to current comorbid conditions. Respondent took D.B.'s statements at face value, and disregarded conflicting evidence. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

b. Based on the matters stated in Findings 78 through 80, and 86, respondent did not use careful titration in escalating D.B.'s stimulant dose.[16] Instead, respondent increased D.B.'s dose rapidly. Then, respondent failed to consider whether D.B. suffered adverse negative effects from her stimulant medication. Respondent did not monitor D.B.'s vital signs regularly, or maintain contact with a primary care physician who did. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

c. Based on the matters stated in Findings 74, 80, and 90, respondent failed to observe that D.B. deteriorated, rather than improved, under respondent's care, and failed to assess whether D.B. was abusing her medication. The matters stated in Findings 74, 89, and 90 established that D.B.'s employment status changed while she treated with D.B., but they did not establish that her psychological function deteriorated. Further, the matters stated in Findings 80, 83, and 86 established D.B.'s inconsistent compliance with respondent's recommendations, but the matters stated in Finding 88 did not establish that she ever abused or misused her medication. For these reasons, this opinion by Dr. Berg is not persuasive.

d. Based on the matters stated in Findings 77, 78, 81 through 84, and 86, respondent failed to play any meaningful role in diagnosing D.B. or in guiding the course of her treatment. He permitted D.B. to decide what medications she would and would not take, and permitted her to choose her own therapies. Although respondent ordered certain diagnostic tests, including a SPECT study, for D.B., he did not insist that she undergo them and did not use the results in his treatment. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

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[16] Complainant made similar allegations regarding clonazepam, but the evidence did not establish that respondent ever prescribed clonazepam for D.B.

92. Based on the matters stated in Findings 75, 78, 80, and 86, Dr. Berg opined that respondent prescribed stimulants to D.B. without medical indication, and continued to do so throughout her treatment. Dr. Berg's opinion is persuasive.

93. Based on the matters stated in Findings 78, 80, and 86, Dr. Berg opined that even if stimulant medication had been appropriate for D.B., respondent prescribed it in clearly excessive amounts. Because the evidence, as summarized in Finding 88, did not establish that D.B. misused her medication, or that she suffered other negative effects that could be attributed only to medication, this opinion is not persuasive.

94. Dr. Berg also opined that respondent committed simple departures from the standards of care described in Findings 12 and 13 in treating D.B. In particular:

a. Based on the matters stated in Findings 78 and 83 through 85, respondent prescribed Strattera, Abilify, Adderall, Intuniv, and Topamax to D.B. without documenting full discussion of these drugs' risks or addictive potential. Although the evidence regarding respondent's disclosures to D.B. regarding these medications is skimpy, it does not establish that respondent failed to explain these medications to D.B. Dr. Berg's opinion that these failures represent simple departures from the care a reasonably prudent physician would have provided under similar circumstances is not persuasive.

b. Based on the matters stated in Finding 84, respondent prescribed Topamax without taking a pertinent medical history, without performing any physical examination, and without consulting with any other clinician who might previously or concurrently have prescribed this medication to D.B. Dr. Berg's opinion is persuasive that this failure represents a simple departure from the care a reasonably prudent physician would have provided under similar circumstances.

95. Based on the matters stated in Findings 73, 78, 81, and 84, Dr. Berg opined that respondent failed to maintain complete, accurate, and adequate records describing his treatment of D.B. Dr. Berg's opinion is persuasive that respondent's records are inadequate.

96. Dr. Blinder opined that respondent provided adequate, responsible care to D.B. He did not believe that respondent erred in prescribing Topamax to D.B., or that he was too quick to dismiss D.B.'s anxiety and paranoia as possible negative effects from stimulant use. In light of all the evidence about D.B., these opinions are not persuasive.

97. Dr. Goodman opined that respondent provided "reasonable and thoughtful" care to D.B. He identified no errors that he believed represented treatment falling below the relevant standards of care. In particular, Dr. Goodman did not conclude that respondent ever prescribed medication to D.B. that her symptoms did not warrant, and concluded that respondent did document adequate discussions with D.B. regarding the benefits and risks of treatment. In light of all the evidence about D.B., these opinions are not persuasive.

Patient J.A.

98. Drs. Berg, Blinder, and Goodman reviewed respondent's records regarding J.A. and rendered opinions based on their reviews. In addition, respondent testified regarding his treatment of J.A. Respondent's records for J.A. also included results from a SPECT study, but no other treating physicians' records otherwise were in evidence. Neither J.A. nor anyone in her family testified.

RESPONDENT'S CARE FOR PATIENT J.A.

99. Respondent saw J.A. first on February 2, 2011. She was 52 years old and had not been employed outside her home since 1986 despite having an advanced degree in biophysics.

100. J.A. came to respondent upon referral from her primary care physician. J.A. said that she suspected that she had ADHD because other clinicians had diagnosed it in one of her children and a few of her nieces and nephews. She also said, however, that she had used phentermine[17] daily for "several years" but that it recently had "stopped working."

101. Respondent asked J.A. to fill out several questionnaires seeking her self-report about mental health. J.A.'s husband also filled out one seeking his report of behavior or symptoms by J.A. that might indicate ADHD. Although J.A. gave herself high scores ("very frequently") on most symptoms that might indicate an attention disorder, such as "[s]hort attention span," "tendency to drift away" and "distractibility," J.A.'s husband stated that J.A. never exhibited any of these qualities. Respondent's notes do not state that he explored these divergent reports, or took them into account in treating J.A.

102. Respondent referred J.A. immediately for a brain SPECT study, which J.A. obtained. The referral form states that respondent wished to rule out "fronto-temporal dysfunction" and "subclinical epilepsy." Respondent's notes show that he reviewed the study results, but do not reflect that he used them in any way to guide his treatment of J.A.

103. At J.A.'s second visit, respondent prescribed Adderall, initially as 5 milligrams twice per day and then as 10 milligrams twice per day. He recorded J.A.'s blood pressure at this visit, on February 15, 2011; it was borderline high. The evidence did not establish that respondent discussed carefully all risks of stimulant medication with J.A., or in particular that he cautioned her that using them could raise her blood pressure dangerously.

[17] Phentermine has stimulant effects but is not an amphetamine. It is a dangerous drug and a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (f)(4).

104. In late February 2011 respondent prescribed Prozac[18] for J.A., but in May 2011 he switched to Cymbalta.[19] The evidence did not establish that respondent discussed the risks of these drugs with J.A., or that he consulted with any other physician who may have been treating J.A. before prescribing them.

105. Respondent's notes state that J.A.'s blood pressure on August 4, 2011, was again borderline high. He recommended nevertheless that J.A. increase her Adderall dose from 50 milligrams per day (10 milligrams in 5 doses) to 60 milligrams (two 15-milligram doses and three 10-milligram doses); on August 18 he recommended that she increase this drug further to four 20-milligram doses per day.

106. Between October 2011 and May 2012, respondent continued prescribing Adderall and Cymbalta to J.A., although his notes do not state that she came to his office. Despite these prescriptions, J.A. told respondent in May 2012 that she had not taken Cymbalta in "6 mos." She also told him at this appointment that she intended to pursue "hormone replacement therapy," possibly including "growth hormone"; the records did not reflect any effort by respondent to counsel J.A. about this course of action, or to coordinate care with any other providers.

107. Respondent's notes do not show that he saw J.A. again until February 5, 2013, although he continued after May 2012 to prescribe Adderall to her. J.A. reported to respondent in February 2013 that she had undergone back surgery, and also that she had resumed taking Cymbalta in November 2012. His notes reflect no effort to learn more about the surgery, but respondent prescribed both Cymbalta and Adderall to J.A. on this date.

108. In July 2013 J.A. reported that she again had discontinued Cymbalta, because she did not like its negative effects. She asked respondent to prescribe Effexor[20] to her, because one of her relatives had used it successfully; respondent complied. Respondent's notes include another blood pressure measurement from this time period, again high; respondent counseled J.A. in August 2013 to reduce her salt intake, but did not modify her medication regimen.

109. Respondent's records regarding J.A. include a written "Patient Informed Consent for Psychostimulant Medications" similar to the one described above in Finding 28. It bears J.A.'s apparent signature, and the date "7-23-13."

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[18] Prozac, or fluoxetine hydrochloride, is an anti-depressant medication. It is a dangerous drug.

[19] Cymbalta, or duloxetine, is an anti-depressant medication. It is a dangerous drug.

[20] Effexor, or venlafaxine hydrochloride, is an anti-depressant medication. It is a dangerous drug.

110. J.A. did not return to see respondent until February 2014, when she reported that she had stopped taking Effexor about a month earlier. Respondent kept J.A. on 80 milligrams of Adderall per day, and prescribed Prozac. J.A. took this drug for a few months but reported to respondent in June 2014 that she had stopped.

111. J.A. also reported to respondent in June 2014 that she was seeing a "new" physiatrist for chronic pain. Respondent noted that he would contact this clinician to coordinate on J.A.'s medications, although his notes include no evidence that he did.

112. Respondent's notes from a visit with J.A. in June 2015 state that she had begun taking oxycodone[21] for back pain, and that she had been taking "growth hormone" for about two years. The notes also say that J.A.'s other physicians were "not concerned" about her taking both stimulants and Cymbalta, although the notes do not reflect that respondent received this information directly from any other physicians. He prescribed Cymbalta to J.A., and then learned at her next appointment in July 2015 that her physiatrist had been prescribing it and she had been taking it for more than a year.

113. After September 2015, respondent prescribed only Adderall to J.A.

114. On February 3, 2016, respondent learned that J.A. again had stopped taking Cymbalta, this time because of concerns over her liver function. She continued taking oxycodone at a stable dose, but reported to respondent that Adderall was also helpful in controlling pain. Respondent's notes reflect a discussion about J.A.'s use of oxycodone and Adderall in the previous years, and about her abstinence from alcohol, cannabis, or other unprescribed drugs. Because he observed no history of drug misuse or escalating tolerance, respondent increased J.A.'s Adderall prescription from 80 milligrams per day in four doses to 100 milligrams per day in five doses.

115. On June 7, 2016, respondent obtained a CURES report regarding J.A., covering approximately the previous year. This report is the only such report in J.A.'s record. It discloses that on February 1, 2016, J.A. had received treatment with ketamine,[22] administered by a different physician. Respondent's notes from J.A.'s February 3, 2016, appointment reflect no discussion of this treatment, suggesting that J.A. did not disclose it to respondent. Yet notes from J.A.'s visits with respondent after June 7, 2016, also reflect no discussion of this treatment, and no effort by respondent to consult with the physician who administered ketamine to J.A.

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[21] Oxycodone is a narcotic drug. It is a dangerous drug and is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M).

[22] Ketamine is an anesthetic drug sometimes used in treating depression. It is a dangerous drug and is a Schedule III controlled substance under Health and Safety Code section 11056, subdivision (g).

116. The evidence did not establish that J.A. ever took more stimulant medication than respondent had prescribed, or that she ever asked respondent to prescribe replacement stimulant medication.

117. Throughout the course of her treatment with respondent, and according to respondent's notes, J.A. reported consistent mental health complaints, but worsening physical health. She underwent at least two spinal surgeries between 2013 and 2016 and experienced other problems that led to chronic pain. The evidence did not establish that J.A.'s treatment with respondent caused or worsened any of these physical health problems.

EXPERT OPINIONS REGARDING RESPONDENT'S CARE FOR PATIENT J.A.

118. Dr. Berg opined that respondent committed extreme departures from the standards of care described in Findings 8 through 11 in treating J.A. In particular:

a. Based on the matters stated in Findings 100 through 102, respondent failed to make an adequate initial assessment of J.A.'s risk for substance abuse, failed to perform a complete psychiatric evaluation, and failed to give adequate consideration to past psychiatric problems or to current comorbid conditions. Respondent took J.A.'s statements at face value, and disregarded conflicting evidence. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

b. Based on the matters stated in Findings 103, 105, and 108, respondent did not use careful titration in escalating J.A.'s stimulant dose.[23] Instead, respondent increased J.A.'s dose rapidly, and failed to consider whether J.A. suffered adverse negative effects from her stimulant medication. Respondent did not monitor J.A.'s vital signs regularly, or maintain contact with a primary care physician who did. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

c. Based on the matters stated in Findings 106, 107, 110 through 112, and 114, respondent failed to observe that J.A. deteriorated, rather than improved, under respondent's care, and failed to assess whether J.A. was abusing her medication. The matters stated in Finding 117 established that J.A.'s physical health deteriorated while she treated with respondent, but not her mental health. Further, the matters stated in Finding 116 did not establish that J.A. ever abused or misused her medication. For these reasons, this opinion by Dr. Berg is not persuasive.

d. Based on the matters stated in Findings 101, 102, 106 through 112, 114, and 115, respondent failed to play any meaningful role in diagnosing J.A. or in guiding the course of her treatment. J.A. received care from several other physicians while treating

[23] Complainant made similar allegations regarding clonazepam, but the evidence did not establish that respondent ever prescribed clonazepam for J.A.

with respondent. Some of these other physicians also prescribed controlled substances to her, and prescribed anti-depressant medication (Cymbalta) that would have been dangerous if J.A. had taken Prozac or Effexor prescribed simultaneously by respondent. Yet respondent relied solely on J.A. to act as an intermediary between him and her other providers, rather than collaborating with them to ensure that they neither duplicated treatment nor provided conflicting treatment. He ordered a SPECT study, yet failed to use the results in planning J.A.'s care. Dr. Berg's opinion is persuasive that these failures represent an extreme departure from the care a reasonably prudent physician would have provided under similar circumstances.

119. Based on the matters stated in Findings 100 through 103, Dr. Berg opined that respondent prescribed stimulants to J.A. without medical indication, and continued to do so throughout her treatment. Dr. Berg's opinion is persuasive.

120. Based on the matters stated in Findings 103, 105, 110, and 114, Dr. Berg opined that even if stimulant medication had been appropriate for J.A., respondent prescribed it in clearly excessive amounts. Because the evidence, as stated in Finding 116, did not establish that J.A. misused her medication, or that she suffered other negative effects that could be attributed only to medication, this opinion is not persuasive.

121. Dr. Berg also opined that respondent committed a simple departure from the standards of care described in Finding 12 in treating J.A. Based on the matters stated in Finding 103, respondent prescribed Adderall to J.A. without documenting full discussion of this drug's risks or addictive potential. Dr. Berg's opinion that this failure represents a simple departure from the care a reasonably prudent physician would have provided under similar circumstances is persuasive.

122. Based on the matters stated in Findings 98, 101, 104, 106, and 107, Dr. Berg opined that respondent failed to maintain complete, accurate, and adequate records describing his treatment of J.A. Dr. Berg's opinion is persuasive.

123. Dr. Blinder opined that respondent provided appropriate care to J.A. He did not believe that respondent erred in treating J.A. for ADHD despite her husband's denial that she had any symptoms, or that he escalated her medication dose too quickly. In light of all the evidence about J.A., these opinions are not persuasive.

124. Dr. Goodman also opined that respondent provided appropriate care to J.A. He identified no errors that he believed represented treatment falling below the relevant standards of care. Dr. Goodman believed that respondent evaluated J.A. with sufficient care, and gave proper attention to J.A.'s other medical treatments. In light of all the evidence about J.A., these opinions are not persuasive.

Other Evidence

125. Respondent provided current reference letters from two medical professionals who know and respect his work.

a. Gregory Saccone, M.D., has been respondent's friend since the 1980's. Although they have not practiced medicine together, they have remained in contact since they met and sometimes discuss their medical practices. Dr. Saccone is an internist, and has referred patients to respondent because he trusts respondent's clinical judgment.

b. Eva Weinlander, M.D., is a family practice physician in Palo Alto. She has referred patients to respondent when she suspects ADHD, and she trusts respondent's clinical judgment.

126. Respondent provided also provided three reference letters dated in 2015, while the matter described above in Finding 2 was pending, from other medical professionals.

a. Daniel G. Amen, M.D., trained respondent in use of the SPECT imaging system. Dr. Amen stated that respondent always had shown himself to be "ethical, effective, kind and compassionate with patients."

b. Anita Hirsch, M.D., is a psychiatrist. She was in private practice in 2015 but had worked for respondent in the past. She had strong praise for his "methodical" diagnostic skills, noting that he spent time evaluating and then monitoring each patient. She has referred patients to respondent, including members of her family.

c. Gabriele Hillberg, Ph.D., was a psychotherapist in private practice in 2015. She had collaborated with respondent in patient treatment since 2001; at the time Dr. Hillberg prepared her letter, she and respondent had patients in common. Dr. Hillberg trusted respondent's judgment, and stated that their common patients spoke highly of his care.

127. Respondent also provided reference letters from adult patients who he treats or has treated for ADHD. These patients' common experience is that respondent has been very informative during their treatment, discussing the benefits and risks of stimulant medication with them in a manner permitting them to understand and trust his decisions. They also respect and appreciate his close attention to their psychological function.

128. While respondent was on probation, as described above in Finding 2, he completed courses through the Western Institute of Legal Medicine on prescribing practices and on medical record keeping. In addition, since 2015 respondent has undertaken regular continuing medical education through the American Medical Association.

LEGAL CONCLUSIONS

1. The Board may suspend or revoke respondent's physician's and surgeon's certificate if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Business and Professions Code section 2234 makes a physician's unprofessional conduct grounds for suspension or revocation of the physician's certificate.

3. Unprofessional conduct includes:

a. Gross negligence, connoting an extreme departure from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (b));

b. Repeated negligent acts, connoting multiple distinct departures from the minimum professionally accepted standard of care (*id.*, subd. (c));

c. Incompetence (*id.*, subd. (d));

d. Prescribing or furnishing dangerous drugs, as Business and Professions Code section 4022 defines such drugs, without an appropriate prior examination and a medical indication (*id.*, § 2242, subd. (a));

e. Repeatedly prescribing clearly excessive amounts of medication without medical indication (*id.*, § 725); and

f. Failing to maintain adequate and accurate patient records (*id.*, § 2266).

Causes for Discipline, Patient J.S.

4. The matters stated in Finding 67 constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (b), for gross negligence.

5. The matters stated in Findings 69.b, in combination with the matters stated in Legal Conclusions 11 and 18, constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (c), for repeated acts of simple negligence.

6. Although the matters stated in Findings 67 and 69.b establish medical decisions falling below the standard of care, they do not establish that respondent's medical decisions were incompetent. They do not constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (d).

7. The matters stated in Finding 68 constitute cause for discipline against respondent under Business and Professions Code sections 725, 2234, and 2242, subdivision (a), for prescribing clearly excessive amounts of dangerous drugs.

8. The matters stated in Finding 70 constitute cause for discipline against respondent under Business and Professions Code sections 2234 and 2266, for maintaining inadequate medical records.

Causes for Discipline, Patient D.B.

9. The matters stated in Finding 3 establish that the matters described in Findings 76 through 78 occurred more than seven years before complainant filed the accusation in this matter. Under Business and Professions Code section 2230.5, subdivision (a), these matters do not constitute cause for discipline against respondent.

10. Because of the matters stated in Legal Conclusion 9, the matters stated in Finding 91.a do not constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (b), for gross negligence.

11. Except as stated in Legal Conclusion 9, the matters stated in Findings 91.b and 91.d constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (b), for gross negligence.

12. The matters stated in Finding 94.b, in combination with the matters stated in Legal Conclusions 5 and 18, constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (c), for repeated acts of simple negligence.

13. Although the matters stated in Findings 91.b, 91.d, and 94.b establish medical decisions falling below the standard of care, they do not establish that respondent's medical decisions were incompetent. They do not constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (d).

14. The matters stated in Finding 92 establish that respondent prescribed stimulant medication to D.B. without medical indication, which is cause for discipline against respondent under Business and Professions Code sections 2234 and 2242, subdivision (a).

15. The matters stated in Finding 93 do not establish that respondent's prescriptions for D.B. were clearly excessive. They do not constitute cause for discipline against respondent under Business and Professions Code sections 725 and 2234 for prescribing clearly excessive amounts of dangerous drugs.

16. The matters stated in Finding 95 constitute cause for discipline against respondent under Business and Professions Code sections 2234 and 2266 for maintaining inadequate medical records.

Causes for Discipline, Patient J.A.

17. The matters stated in Findings 118.a, 118.b, and 118.d constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (b), for gross negligence.

18. The matters stated in Finding 121, in combination with the matters stated in Legal Conclusions 5 and 11, constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (c), for repeated acts of simple negligence.

19. Although the matters stated in Findings 118.a, 118.b, 118.d, and 121 establish medical decisions falling below the standard of care, they do not establish that respondent's medical decisions were incompetent. They do not constitute cause for discipline against respondent under Business and Professions Code section 2234, subdivision (d).

20. The matters stated in Finding 119 establish that respondent prescribed stimulant medication to J.A. without medical indication, which is cause for discipline against respondent under Business and Professions Code sections 2234 and 2242, subdivision (a).

21. The matters stated in Finding 120 do not establish that respondent's prescriptions for J.A. were clearly excessive. They do not constitute cause for discipline against respondent under Business and Professions Code sections 725 and 2234 for prescribing dangerous drugs in clearly excessive amounts.

22. The matters stated in Finding 122 constitute cause for discipline against respondent under Business and Professions Code sections 2234 and 2266 for maintaining inadequate medical records.

Disciplinary Considerations

23. As stated in Finding 2, respondent completed a previous period of probation because of similar practice errors. His continuation of these errors is cause for concern; on the other hand, the matters stated in Findings 125 and 126 establish that many clinicians do respect his judgment and appreciate his role in the local medical community. A further period of probation will permit the Board to monitor respondent's medical judgment while permitting him to continue serving the local medical community.

24. Because of the matters stated in Findings 5, 67.d, 91.d, and 118.d, however, the public welfare requires the Board to restrict respondent's ability to practice medicine without regular consultation with other medical colleagues. In addition, and despite the matters stated in Finding 128, further remedial courses are appropriate in this case.

ORDER

Physician's and Surgeon's Certificate No. G 72442, first issued to respondent Matthew Sinclair Stubblefield in September 1991, is revoked. The revocation is stayed, however, and respondent is placed on probation for five years upon the following terms and conditions:

1. Controlled Substances: Maintain Records and Access to Records and Inventories

   Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

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

2. Education Course

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

3. 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the 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.

4. Medical Record Keeping Course

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

5. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a professionalism program that meets the requirements of section 1358.1 of title 16 of the California Code of Regulations. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the decision, whichever is later.

6. 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 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 (ABMS) pertaining to respondent's current 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 and no more than five 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 calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program has been completed. If respondent did not successfully complete the clinical competence assessment program, 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.

7. Practice Monitor

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 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.

The Board or its designee shall provide the approved monitor with copies of the decision and accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 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 medical practice, and whether respondent is practicing medicine safely. 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 five 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 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.

8. 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 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, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this decision, respondent shall notify the Board or its designee within five 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 calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

9. Notification

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

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

10. Obey All Laws

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

11. 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.

12. General Probation Requirements

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

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

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

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

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

13. 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.

14. Non-Practice While on Probation

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

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

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

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

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws (Condition 10); and General Probation Requirements (Condition 12).

15. 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.

16. 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.

17. License Surrender

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

18. 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.

DATED: August 20, 2018

DocuSigned by:
Juliet E. Cox
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MATTHEW SINCLAIR STUBBLEFIELD, M.D.** **3303 Alma Street** **Palo Alto, CA 94306** **Physician's and Surgeon's Certificate No. G 72442,** Respondent.	Case No. 800-2016-019765 **ACCUSATION**

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 September 10, 1991, the Medical Board issued Physician's and Surgeon's Certificate Number G 72442 to Matthew Sinclair Stubblefield, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2018, unless renewed. Said certificate was revoked, stayed, subject to probation for a period of two (2) years effective November 20, 2015.

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 unless otherwise indicated.

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

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. Section 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."

6. Section 2227 of the Code authorizes the Board to discipline a licensee and obtain probation costs.

7. Section 2228 of the Code authorizes the Board to discipline a licensee by placing them on probation.

8. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

9. 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."

10. 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."

11. 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."

12. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229(c) states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

13. **Abilify** (aripiprazole) is an antipsychotic medication. It works by changing the actions of chemicals in the brain. Abilify is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It is also used together with other medications to treat major depressive disorder in adults. It is also used to treat irritability and symptoms of aggression, mood swings, temper tantrums, and self-injury related to autistic disorder in children who are at least 6 years old. It is a dangerous drug as defined in Business and Professions Code section 4022.

14. **Adderall**, a trade name for mixed salts of a single-entity amphetamine product (dextroamphetamine sulphate, dextroamphetamine saccharate, amphetamine sulfate, amphetamine aspartate), is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Adderall is indicated for Attention Deficit Disorder with Hyperactivity and Narcolepsy for Deficit Disorder with Hyperactivity, only in rare cases will it be necessary to exceed a total of 40

mg per day. For Narcolepsy, the usual dose is 5 mg to 60 mg per day in divided doses depending on individual patient response.

15. **Ativan**, the trade name for lorazepam, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures. The usual dosage range is 2 to 6 mg a day given in divided doses, the largest dose being taken before bedtime, but the daily dosage may vary from 1 to 10 mg a day.

16. **Buspirone hydrochloride**, an anti-anxiety agent that is chemically or pharmacologically related to benzodiazepines, barbiturates, or other sedative/anxiolytic drugs. The concomitant use of buspirone with other central nervous system (CNS) - active drugs should be approached with caution. Buspirone is a dangerous drug as defined in section 4022 of the Code.

17. **Celexa**, a trade name for citalopram hydrobromide, is a selective serotonin reuptake inhibitor ("SSRI") with a chemical structure unrelated to that of other SSRIs or of tricyclic, tetracyclic, or other available antidepressant agents and is used in the treatment of depression. It has primary CNS depressant effects and should be used with caution in combination with other centrally acting drugs. Celexa is a dangerous drug as defined in section 4022 of the Code.

18. **Citalopram hydrobromide**, known by the trade name Celexa, is a selective serotonin reuptake inhibitor ("SSRI") with a chemical structure unrelated to that of other SSRIs or of tricyclic, tetracyclic, or other available antidepressant agents and is used in the treatment of depression. It has primary CNS depressant effects and should be used with caution in combination with other centrally acting drugs. Celexa is a dangerous drug as defined in Business and Professions Code section 4022 of the Code.

19. **Clonazepam**, known by the trade name Klonopin, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in Business and Professions

Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of clonazepam. The initial dosage for adults should not exceed 1.5 mg. per day divided in three doses.

20. **Cymbalta**, also known as Duloxetine, is used to treat depression and anxiety. In addition, it is used to help relieve nerve pain in people with diabetes or ongoing pain due to medical conditions such as arthritis, chronic back pain, or fibromyalgia.

21. **Effexor** is a trade name for venlafaxine hydrochloride, a dangerous drug as defined in Business and Professions Code section 4022. Effexor is indicated for the treatment of depression. It is chemically unrelated to tricyclic, tetracyclic, or other available antidepressant agents.

22. **Fen/Phen**, the trade name for the drug combination fenfluramine/phentermine. It was an anti-obesity treatment that was eventually shown to cause potentially fatal pulmonary hypertension and heart valve problems. The product was eventually pulled from the market.

23. **Gabitril**, the trade name for Tiagabine. Gabitril, is an anticonvulsant medication used in the treatment of epilepsy. The drug is also used off-label in the treatment of anxiety disorders and panic disorder. It may induce seizures in those without epilepsy, particularly if they are taking another drug which lowers the seizure threshold. It is a dangerous drug as defined in Business and Professions Code section 4022.

24. **Imitrex** is a trade name for Sumatriptan, which is used to treat migraines. Side effects include tingling/numbness/prickling/hear, tiredness, weakness, drowsiness, or dizziness. It is a dangerous drug as defined in Business and Professions Code section 4022.

25. **Intuniv** is a trade name for guanfacine, which is used to treat attention deficit hyperactivity disorder (ADHD). Side effects include drowsiness, dizziness, nausea, headache and stomach pain. This a dangerous drug as defined in Business and Professions Code section 4022.

26. **Levothyroxine**, is indicated as replacement or substitution therapy for diminished or absent thyroid function resulting from functional deficiency, primary atrophy, from partial or

complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

27. **Oxycodone** is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

28. **Phentermine hydrochloride**, known by the brand name Fastin, a sympathomimetic amine with pharmacologic activity similar to amphetamines. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057, subdivision (f) of the Health and Safety Code. It is related chemically and pharmacologically to the amphetamines and the possibility of abuse should be kept in mind when evaluating the desirability of including this drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. It is contraindicated for patients with a history of drug abuse.

29. **Prozac**, a trade name for fluoxetine hydrochloride, an antidepressant, is a dangerous drug within the meaning of Business and Professions code section 4022. Prozac is an antidepressant agent chemically unrelated to tricyclic, tetracyclic, or other available antidepressant agents. A significant percentage (12 to 16%) of patients on Prozac experienced anxiety, nervousness, or insomnia. In general, the maximum dose of fluoxetine should not exceed 80 mg per day.

30. **Ritalin**, the trade name for methylphenidate hydrochloride, is a CNS stimulant indicated for the treatment of attention deficit hyperactivity disorder ("ADHD"). Ritalin, or methylphenidate, should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior. The minimum dosage is one, 18 mg. tablet daily; the maximum dosage is one, 54 mg. tablet daily. Ritalin, or methylphenidate, is a dangerous drug as

defined in section 4022 of the Code and a Schedule II controlled substance under Health and Safety Code section 11055(d)(6).

31. **Strattera**, also known as Atomoxetine, is used to treat attention-deficit hyperactivity disorder (ADHD) as part of a total treatment plan, including psychological, social, and other treatments. It may help to increase the ability to pay attention, concentrate, stay focused, and stop fidgeting. It is thought to work by restoring the balance of certain natural substances (neurotransmitters) in the brain. It is a dangerous drug as defined in Business and Professions Code section 4022.

32. **Topamax**, a trade name for topiramate, is used to prevent migraine headaches and to prevent seizures (epilepsy). It is a dangerous drug within the meaning of Business and Professions Code section 4022.

33. **Vyvanse**, also known as Lisdexamfetamine, is a central nervous system stimulant. It is a dangerous drug within the meaning of Business and Professions Code section 4022. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Vyvanse is used to treat attention deficit hyperactivity disorder (ADHD) in adults and in children who are at least 6 years old. Vyvanse is also used to treat moderate to severe binge eating disorder in adults. This medicine is not to be used for obesity or weight loss.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, and/or Repeated Negligent Acts; and/or Incompetence; and/or Excessive Prescribing; and/or Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient JS) [1]

34. Respondent Matthew Sinclair Stubblefield, M.D. is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and/or 2234(d), and/or 2266 of the Code in that Respondent committed unprofessional conduct amounting to gross negligence and/or repeated negligent acts and/or incompetence in the care and treatment of Patient JS, and/or failed to maintain adequate and accurate records for Patient JS. Respondent is also subject to

[1] Patient initials are used to protect their privacy. Respondent may learn the names of the patients through the discovery process.

disciplinary action under sections 725 and 2242(a) of the Code in that Respondent excessively prescribed to Patient JS without proper medical examination or indication. The circumstances are as follows:

35. On or about March 24, 2014, Patient JS, a then 30-year old male, was first seen by Respondent. JS had just finished law school and had taken the California Bar examination the month prior. For the previous three years, Patient JS had been treated for anxiety and ADHD by a provider in Boston who had prescribed Ritalin SR and clonazepam.

36. JS had also been diagnosed hypothyroid and was prescribed a daily dosage of levothyroxine by a previous treater.

37. At that first meeting, Respondent moved JS from Ritalin to Vyvanse without documenting in the progress note why the medications were changed. Respondent never explored the history of substance abuse with JS and never received collateral information to support JS's claims of anxiety and ADHD.

38. There was no toxicology screen performed at or around the first visit.

39. Respondent failed to timely and appropriately check JS's vitals when increasing the patient's medications. In fact, the progress notes for JS were so poor that it is difficult to determine the dosages provided to JS. Additionally, the dosage amounts written in both the progress note and the medication sheet were not always consistent. Furthermore, Respondent's handwritten progress notes for JS were almost illegible.

40. On August 25, 2014, Respondent finally diagnosed JS with ADHD. Yet, this was the 10th patient visit and JS had already been prescribed Vyvanse 140 mg bid and Adderall 30 mg.

41. On October 22, 2014, Dr. S of Kaiser called Respondent due to concern for the high dosages prescribed by Respondent. Shortly thereafter, Respondent learned that Dr. S had been treating JS concurrently and had prescribed #90 of Vyvanse 60 mg in May 2014, at the same time Respondent had prescribed #15 Vyvanse 50 mg.

42. On November 11, 2014, Respondent prescribed #120 Vyvanse 60 mg. This prescription was listed on the medication sheet, but there is no progress note for that date. On

December 4, 2014, JS received #110 Vyvanse 60 mg from Respondent. This prescription was not listed on the medication sheet, and again, there was no progress note for that date.

43. On November 25, 2014, and again on December 8, 2014, JS failed to appear for appointments – no notations were made in the progress notes about these missed appointments – and JS did not present again to Respondent until March 12, 2015.

44. In the meantime, on December 23, 2014, and January 5, 2015, JS received #60 Vyvanse 60 mg, #200 Vyvanse 60 mg from Dr. S., respectively, and, then #30 Vyvanse 70 mg prescribed by Dr. D on February 28, 2015. On March 12, 2015, Respondent once again saw JS, prescribed to JS, yet failed to note in any progress or medical records that Respondent informed Dr. S that Respondent was resuming prescribing to JS.

45. On three occasions, July 2, 2014, June 30, 2015, and January 5, 2016, JS claimed that stimulant medication (Vyvanse) was either lost or stolen. Yet, Respondent only gave JS a warning, wrote early refills and even increased the dosages after the stimulant medication was reported lost or stolen.

46. When the parents of JS attempted to provide information to Respondent regarding their son's abuse of stimulants, Respondent refused to communicate with them. In fact, there are no notations in JS's progress reports that Respondent tried to get a release to talk with the parents, all the while JS was abusing stimulants and Respondent continually took the patient's statements at face value. Respondent did not seek out corroborating observations, coordinate with other providers, obtain treatment records from other providers, or confront the patient.

47. Respondent did not utilize CURES even though JS was on high dosages of stimulants and Respondent permitted JS to determine the amount of dosage to take.

48. On or about December 30, 2015, Respondent prescribed clonazepam to JS for the first time. Respondent failed to place a notation in the progress note regarding the rationale for initiating the treatment, the medication choice or discussion of risk or benefits of the medicine choice, or of the addictive potential of the medicine choice.

49. On or about January 5, 2016, just six (6) days after starting JS on clonazepam, Respondent tripled the dosage without waiting to determine how well JS responded to the controlled substance once it had reached a steady blood level.

50. On or about January 16, 2016 Respondent corresponded with JS via unencrypted text regarding the patient's prescription for Adderall in violation of HIPAA.

51. On or about January 29, 2016, JS was admitted to a rehabilitation program for substance abuse.

52. Respondent failed to assess the deterioration of JS to consider whether Respondent's treatment could be contributory. In fact, when JS last saw Respondent, JS was unable to hold down a job as a driver for Lyft.

53. Respondent's overall care and treatment of Patient JS constitutes unprofessional conduct through gross negligence and/or repeated negligent act and/or incompetence and/or excessive prescribing and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain accurate and adequate medical records including, but not limited to the following:

a. Respondent failed to assess JS for substance abuse even with JS receiving high doses of addictive agents, and even after JS claimed to have lost or had stolen stimulant medication on three occasions;

b. Respondent provided no notation that he tried to get a release to speak with the parents of JS regarding the possibility of substance abuse;

c. Respondent failed to conduct a complete psychiatric evaluation, or to consider past symptoms and comorbid conditions pertinent to assessing a patient being evaluated for ADHD or ADD;

d. Respondent failed to properly manage JS when treating for ADHD or ADD, including but not limited to:

i. Escalating the dose of stimulants often without monitoring specific symptoms and how they affected functioning;

ii. Failing to proceed in a measured and methodical fashion to reach appropriate doses of stimulants and clonazepam, even increasing the dosing when the patient reported doing better;

iii. Failing to adequately monitor vital signs in spite of very large doses which far exceeded guidelines;

iv. Failing to monitor doses to consider psychiatric adverse effects of prescribed doses and actually increasing doses to deal with symptoms which might be due to the medications;

v. Failing to assess the deterioration of his patients to consider whether his treatment could be contributory;

vi. Failing to obtain collateral information to assess the potential for misuse or abuse of stimulants.

e. Respondent failed to utilize CURES until he found out that he was under investigation;

f. Respondent violated HIPAA privacy rules by communicating with JS via mobile phone text messaging regarding an Adderall prescription;

g. Respondent allowed JS to self-direct his diagnosis and treatment;

h. Respondent prescribed medication to JS for the first time without noting in the progress notes the prescription or the rationale for the prescription;

i. Respondent failed to keep accurate and adequate medical records.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, and/or Repeated Negligent Acts; and/or Incompetence; and/or Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient DB)

54. Respondent Matthew Sinclair Stubblefield, M.D. is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and/or 2234(d), and/or 2266 of the Code in that Respondent committed unprofessional conduct amounting to gross negligence and/or repeated negligent acts and/or incompetence in the care and treatment of Patient DB, and/or failed to maintain adequate and accurate records for Patient DB. Respondent is also subject to

disciplinary action under sections 725 and 2242(a) of the Code in that Respondent excessively prescribed to Patient DB without proper medical examination or indication. The circumstances are as follows:

55. On or about December 17, 2007, patient DB, a then 39-year old female, was first seen by Respondent. DB, an employed statistical programmer, wished to learn if she had ADD. Six (6) psychiatrists/therapists had treated DB for depression and anxiety prior to her treating with Respondent.

56. DB treated with Respondent until October 13, 2016. By the time her treatment with Respondent ended, DB had been unemployed since March 2014.

57. DB reported a family history of alcoholism on both sides of the family, and that DB consumed alcohol to help keep herself calm. However, there is no evidence throughout the time that Respondent treated DB that Respondent ever asked how much alcohol DB consumed or how often or that he at any time took a complete substance abuse history.

58. A 2002 Morrissey/Compton Educational Center evaluation in the possession of Respondent reported no evidence to suspect DB had an attention disorder. Its diagnoses were social phobia and generalized anxiety disorder by history.

59. Respondent failed to take vital signs of DB from February 11, 2010, through March 26, 2015. Yet, during this time Respondent prescribed Adderall, Abilify, Intuniv, Strattera, and Topamax.

60. On or about March 15, 2011, DB complained of being alone in the dark and fearing ghosts.

61. On or about May 17, 2011, Respondent ordered a SPECT,[2] which images the brain, but there were no progress notes stating that this was necessary. DB did not undergo the SPECT for some 18 months, November 26, 2012, and even then there still were no progress notes stating why it was necessary, or how that data was provided to or used for DB's treatment.

62. On or about April 12, 2011, DB complains "I hate Chinese people due to how I'm treated at work." DB also complains that her Asian neighbor "dominates me."

[2] Respondent ordered and DB had undergone a SPECT on September 29, 2008.

63. Other than ordering SPECT on June 21, 2011, Respondent took no extensive history of DB's symptoms in an attempt to discern whether DB had Bi-Polar Affective Disorder in light of the symptoms presented.

64. On or about August 1, 2012, Respondent prescribed Topamax to DB without noting in the progress notes the reason for doing so, or that Respondent discussed with DB the risks and benefits. At the time, Respondent was aware that DB had previously complained of migraines, yet Respondent failed to take an adequate medical history and evaluation of the condition that he was treating. Respondent never asked DB about symptoms, including use of Imitrex, triggers, frequency, location, severity, type of pain and duration of DB's headaches, nor did Respondent consider the role of Adderall or Strattera in producing headaches.

65. At the time that Respondent prescribed Topamax, Respondent was aware that DB had a primary care physician.

66. According to Respondent's medication sheet, on or about March 13, 2013, Respondent wrote DB a prescription for #180 Adderall 20 mg tid. However, there is no progress note for that date.

67. According to Respondent's medication sheet, on or about April 21, 2013, Respondent prescribed DB #120 Adderall 20 mg bid. However, there is no progress note for that date.

68. On or about April 22, 2013, and again on June 25, 2013, Respondent prescribed Intuniv to DB. There is no indication that DB ever used Intuniv. The progress notes contain no discussion of DB's non-compliance other than she was afraid it would sedate her.

69. DB did not sign an informed consent form for psychostimulants until June 17, 2013, years after DB began taking Adderall and Strattera at the direction of Respondent.

70. On or about January 7, 2014, DB reported that she had stopped Adderall and Strattera since mid-December 2013, and reported it was "nice being off Adderall, less lip biting." That very appointment Respondent prescribed #120 Adderall 20 mg bid.

71. Respondent failed to proceed in a measured and methodical fashion to reach appropriate doses of stimulants when prescribing for DB. And, in fact, Respondent prescribed

dosages that exceeded standard guidelines, including Strattera 162 mg; and Strattera 120 mg with Adderall 45 mg; and Adderall 120 mg along with Abilify 15 mg.

72. On or about April 28, 2015, DB was complaining that her neighbors were bullying her, causing DB to hole up in a corner so that the neighbors would not know that DB was home.

73. Respondent never explored DB's history of alcohol use, and Respondent failed to assess the deterioration of DB to consider whether Respondent's treatment could be contributory.

74. On or about June 8, 2016, Respondent ran his first CURES report on DB.

75. Respondent's overall care and treatment of Patient DB constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain accurate and adequate medical records including, but not limited to the following:

a. Respondent failed to assess DB for substance abuse even with DB receiving high doses of addictive agents, and after DB reported a family history of alcoholism, and that DB herself consumed alcohol to help keep herself calm;

b. Respondent failed to conduct a complete psychiatric evaluation, or to consider past symptoms and comorbid conditions pertinent to assessing a patient being evaluated for ADHD or ADD;

c. Respondent failed to properly manage DB when treating for ADHD or ADD, including but not limited to:

   i. Escalating the dose of stimulants often without monitoring specific symptoms and how they continue to affect functioning;

   ii. Failing to proceed in a measured and methodical fashion to reach appropriate doses of stimulants and clonazepam, even increasing when the patient reports doing better;

   iii. Failing to adequately monitor vital signs in spite of very large doses which far exceed guidelines;

iv. Failing to monitor doses to consider psychiatric adverse effects of prescribed doses and actually increasing doses to deal with symptoms which might be due to the medications;

v. Ordering expensive diagnostic tests like SPECT without justification in his notes for the necessity of the test and without waiting for the results prior to initiating treatment, and without noting how the test results informed the treatment;

vi. Failing to assess the deterioration of DB to consider whether his treatment could be contributory;

vii. Failing to obtain collateral information to assess the potential for misuse or abuse of stimulants.

d. Respondent failed to consistently chart discussions of his assessment, rationale of treatment and risks and benefits of medications prescribed to DB;

e. Respondent allowed DB to self-direct her diagnosis and treatment;

f. Respondent failed to note discussions with DB regarding DB's non-compliance with prescribed medications;

g. Respondent prescribed medication to DB for the first time without noting in the progress notes the prescription or the rationale for the prescription;

h. Respondent failed to have a signed informed consent before treating DB with stimulants

i. Respondent diagnosed and treated a condition outside of his specialty, without appropriate history, physical assessment, treatment, communication with other providers and/or monitoring the effects of that treatment;

j. Respondent failed to keep accurate and adequate medical records.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; and/or Repeated Negligent Acts; and/or Incompetence; and/or Excessive Prescribing; and/or Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient JA)

76. Respondent Matthew Sinclair Stubblefield, M.D. is subject to disciplinary action under sections 2234, and/or 2234(b), and/or 2234(c), and/or 2234(d), and/or 2266 of the Code in

that Respondent committed unprofessional conduct amounting to gross negligence and/or repeated negligent acts and/or incompetence in the care and treatment of Patient JA, and/or failed to maintain adequate and accurate records for Patient JA. Respondent is also subject to disciplinary action under sections 725 and 2242(a) of the Code in that Respondent excessively prescribed to Patient JA without proper medical examination or indication. The circumstances are as follows:

77. On or about February 2, 2011, patient JA, a then 52-year old female, was first seen by Respondent for an ADD evaluation. During that visit Respondent ordered an expensive diagnostic test, SPECT, which images the brain, without justification in his notes for the necessity of the test and without waiting for the results prior to initiating treatment, and without documenting how the test results informed his treatment of JA.

78. Specifically, on or about February 15, 2011, before Respondent received the SPECT results for JA he placed JA on 5 mg Adderall, twice daily for one week; 10 mg Adderall, twice daily for one week; and then 15 mg Adderall twice daily.

79. JA did not sign an informed consent form for psychostimulants until July 23, 2013, seventeen months after JA began taking Adderall at the direction of Respondent.

80. When JA first saw Respondent, JA provided Respondent a General Adult ADD Symptom Checklist. Respondent was also provided a Checklist from JA's spouse which pertained to JA. There was a significant discrepancy between the two assessments of JA. Yet, Respondent failed to interview the spouse, or record that the spouse had been queried as to any discrepancy.

81. Respondent was aware that JA had used phentermine for many years and, claiming that it lost efficacy, had stopped taking the medicine one month prior to commencing treatment with Respondent. Additionally, Respondent was also aware that JA used alcohol nightly. Yet, Respondent failed to explore any history of substance abuse regarding JA.

82. Respondent showed no concern or curiosity for the idea that JA discontinued antidepressants due to concern about weight gain, had previously used "Fen/phen" and

phentermine, and might be treating with Respondent for the purpose of receiving stimulants in order to keep weight off.

83. During the course of the five years' treatment, which included the prescribing of Adderall and Cymbalta, and the knowledge by June 4, 2015, that JA was also taking oxycodone as prescribed by another treater, Respondent only monitored JA's blood pressure on four (4) occasions: February 15, 2011; August 4, 2011; July 8, 2013; and March 10, 2016. Each of these four blood pressure results were borderline high, and were never addressed. Significantly, there are no progress notes, billings, or medication sheets to confirm that a July 8, 2013, examination ever occurred.

84. On or about July 7, 2015, JA reported to Respondent that she had been taking Cymbalta 60 mg for one and half years as prescribed by a psychiatrist. Respondent was unaware that JA was taking this medicine and had been prescribing Effexor and Prozac at the same time, even though these drugs should not be taken with Cymbalta.

85. On or about June 7, 2016, Respondent obtained a CURES report for JA for the first time. That CURES report noted that JA had been given Ketamine on February 1, 2016, by another treater. Respondent never noted in the progress notes the introduction of Ketamine.

86. Respondent failed to proceed in a measured and methodical fashion to reach appropriate doses of stimulants when prescribing for JA. And, in fact, Respondent prescribed dosages that exceeded standard guidelines, including Adderall 120 mg, and Adderall 100 mg along with Cymbalta up to 120 mg.

87. Respondent permitted JA to direct her own care.

88. Respondent's overall care and treatment of Patient JA constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or excessive prescribing and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain accurate and adequate medical records including, but not limited to the following:

a. Respondent failed to explore a history of substance abuse and took the patient's self-report at face value, ignoring the spouse's discrepancy with JA's self-report;

b. Respondent failed to conduct a complete psychiatric evaluation, or to consider past symptoms and comorbid conditions pertinent to assessing a patient being evaluated for ADHD or ADD;

c. Respondent failed to properly manage JA when treating for ADHD or ADD, including but not limited to:

i. Escalating the dose of stimulants often without monitoring specific symptoms and how they continue to affect functioning;

ii. Failing to proceed in a measured and methodical fashion to reach appropriate doses of stimulants and clonazepam, even increasing when the patient reports doing better;

iii. Failing to adequately monitor vital signs in spite of very large doses which far exceed guidelines, especially when JA's recorded blood pressures were borderline high;

iv. Failing to monitor doses to consider psychiatric adverse effects of prescribed doses and actually increasing doses to deal with symptoms which might be due to the medications;

v. Ordering expensive diagnostic tests like SPECT without justification in his notes for the necessity of the test and without waiting for the results prior to initiating treatment, and without noting how the test results informed his treatment;

vi. Failing to obtain collateral information to assess the potential for misuse or abuse of stimulants.

d. Respondent failed to have a signed informed consent before treating JA with stimulants;

e. Respondent failed to utilize CURES until he found out that he was under investigation;

f. Respondent allowed JA to self-direct her diagnosis and treatment;

g. Respondent failed to stay abreast of other treatments from other providers;

h. Respondent failed to keep accurate and adequate medical records.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 72442, issued to Matthew Sinclair Stubblefield, M.D.;

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

3. Ordering Matthew Sinclair Stubblefield, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: January 03, 2018

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

SF2017402182
accusation - mbc.rtf