XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
GREG W. CHAMBERS
Deputy Attorney General
State Bar No. 237509
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5723
Facsimile: (415) 703-5480
Attorneys for Complainant

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 Said certificate was revoked, stayed, subject to probation for a period of two (2) years effective November 20, 2015.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.

///

///

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