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

In the Matter of the Accusation Against: **ANDREW MICHAEL ABARBANEL, M.D.** **4109 Countrywood Dr. SE** **Rochester, MN 55904-2730** **Physician's and Surgeon's Certificate No. G 47490** Respondent.	Case No. 800-2016-027720 **A C C U S A T I O N**

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 (Medical Board or Board).

2. On June 1, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 47490 to Andrew Michael Abarbanel, 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 September 30, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part,

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

". . . ."

"(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.

". . . ."

6. Section 2266 of the Code states that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 725, subdivision (a), of the Code states, in pertinent part, that "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

FACTS

8. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

PATIENT P-1[1]

9. Patient P-1 was 54 years old when Respondent assumed her care in February 2015. P-1 had been assaulted at work approximately three months earlier and was referred to Respondent for Worker's Compensation psychiatric treatment. Respondent evaluated P-1 on February 17, 2015. Respondent failed to document and/or assess the specifics of the assault on P-1 or her mental state and interpersonal interactions before the assault and, while Respondent mentioned that P-1 had experienced depression with suicidality 10 years previously, he did not address that depression, any treatment for it, or how or whether it had resolved. Respondent did not address P-1's childhood, her past medical history, or what medications or other treatment, if any, she had received. Respondent did not discuss P-1's prescription drug, tobacco, caffeine, or alcohol history or whether she had a history of substance abuse. P-1's family history, past medical history, and social history were sparse. There was a very minimal mental status examination. There was no differential diagnosis and no diagnostic discussion to give a sense of who P-1 was and what her life had been like before the incident. Respondent diagnosed P-1 with Post-Traumatic Stress Disorder (PTSD) and Depressive Episode.

[1] The patients are designated in this document as Patients P-1 through P-4 to protect their and their families' privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

10. Respondent noted that P-1 had been on an extremely low dose of Effexor[2] (37.5 mg) and that P-1 refused to raise the dosage because she had unsuccessfully attempted to increase it in the past. P-1 also refused to consider other antidepressants. P-1 told Respondent that she had taken Xanax[3] and Ativan,[4] 1.0 mg, and that she had been given Nuvigil[5] 250 mg as a sample and that it had helped her. Respondent did not pursue what benefits P-1 had obtained from these medications or under what circumstances she had received them, from whom, and over what period of time. Respondent wrote in his treatment plan that P-1 wanted to run the plan and that he would try to negotiate a change if needed. Because P-1 refused to change the dose or type of antidepressant, Respondent prescribed Nuvigil at the high dose of 250 mg she said she had received as a sample and Ativan 1 mg up to 2 or 3 mg. P-1 failed to tell Respondent that she had been getting Nuvigil 250 mg regularly from multiple providers at multiple pharmacies using two different home addresses dating back at least to January 2013. P-1 also failed to mention that she had been receiving various benzodiazepines from multiple pharmacies and providers. P-1 continued getting Nuvigil and Ativan from other providers while Respondent was treating her and while he was prescribing the same medications. This was reflected on CURES reports that Respondent failed to access and review. Respondent did not discuss the risks and benefits of these medications and did not obtain informed consent from P-1 before prescribing them.

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[2] Effexor, a trade name for venlafaxine, is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). It is a dangerous drug as defined in section 4022.

[3] Xanax, a trade name for alprazolam, is a benzodiazepine used for the management of anxiety disorders for the short-term relief of symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057. Alprazolam is a central nervous system (CNS) depressant.

[4] Ativan, a trade name for lorazepam, is a benzodiazepine. It is a sedative used to treat anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057. Since lorazepam has a central nervous system depressant effect, special care should be taken when prescribing lorazepam with other CNS depressant drugs.

[5] Nuvigil, a trade name for armodafinil, is a wakefulness-promoting agent. It reduces extreme sleepiness due to narcolepsy and other sleep disorders such as obstructive sleep apnea or shift work sleep disorder. Nuvigil tablets come in 50, 150, 200 or 250 mg of armodafinil. Armodafinil is a dangerous drug as defined in section 4022 of the Code and a Schedule IV controlled substance.

Respondent did not document a date for a return visit or establish a standard interval between visits. Only rarely throughout P-1's treatment did Respondent document a return date.

11. On P-1's second visit, March 8, 2015, Respondent took some additional history reflecting family discord. When Respondent asked if P-1 needed medication to treat her anxiety, she declined but asked for Ambien[6] 10 mg, which she said had helped in the past. P-1 mentioned that her back hurt but did not tell Respondent that she had been getting hydrocodone with acetaminophen[7] containing amounts of hydrocodone ranging from 5 mg to 10 mg from various providers at more than one pharmacy and, in the month prior to her seeing Respondent, tramadol[8] 50 mg from three different providers and three different pharmacies. This was reflected on CURES reports, which Respondent could have reviewed but did not.

12. On April 3, 2015, P-1 reported that she had been "re-traumatized" when her nephew fell off a balcony, was seriously injured, and she had to provide his immediate treatment. Although P-1 told Respondent that she couldn't get the visual, the blood, everyone running around, out of her head, Respondent did not document a mental status exam or any inquiry about suicidality.

13. P-1 continued getting Nuvigil from multiple sources. On May 12, 2015, P-1 called for an early refill of Nuvigil and Ativan because she was on her way out of town. P-1 called again May 20, 2015 and reported that, while she was stabilizing, she had increased her Ativan on her own and wanted to have it prescribed 1 mg three times a day. Respondent called the

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[6] Ambien, a trade name for zolpidem tartrate, is a sedative, also called a hypnotic. It is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Dosage adjustment may be necessary when zolpidem tartrate is combined with other central nervous system depressant drugs because of the potentially additive effects. Zolpidem tartrate is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057.

[7] Hydrocodone bitartrate w/APAP (hydrocodone with acetaminophen), also known by the trade name Norco among others, is a combination medication used to relieve moderate to severe pain. Hydrocodone is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and, as of October 6, 2014, a Schedule II controlled substance. Prior to October 2014, it had been a Schedule III controlled substance.

[8] Tramadol hydrochloride is a centrally acting opioid analgesic indicated for the management of moderate to moderately severe pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11057 of the Health and Safety Code.

prescription in as requested by P-1. On June 17, 2015, P-1 called and said she wanted to start Lexapro[9] 10 mg because it had worked in the past. There are no chart notes reflecting Respondent having suggested that P-1 start Lexapro or P-1 having taken it. Although Respondent had not seen P-1 in two months, he called in the prescription. Respondent did not document the number of tablets he was prescribing, the manner in which the medication was to be taken, a discussion of side effects, or whether P-1 would be continuing to take the Effexor.

14. On June 19, 2015, Respondent noted that P-1's depression was getting worse but he did not document having inquired about suicidal ideation. Even though Respondent had initially prescribed Nuvigil for P-1's depression only because she had refused to change antidepressants or increase the dosage of Effexor and even though he had noted at that time that he would negotiate with her to change her antidepressant if the Nuvigil was not working, he had not assessed in subsequent visits how the Nuvigil was affecting her and, with her depression worsening and a new antidepressant, Lexapro, now having been added to her medications, he still did not assess her continued use of Nuvigil. And, although Respondent had increased P-1's Ativan at her request to three times a day because of increased anxiety, he did not assess whether Nuvigil was contributing to the anxiety.

15. On August 7, 2015, P-1 called Respondent complaining again of increased anxiety and asked for a refill of Ativan, which he called in. On August 13, 2015, P-1 said she was really depressed. P-1 declined an increase in the Lexapro saying that she had already tried to increase it and it made her jittery, so Respondent increased her Nuvigil prescription by 50 mg. He did not discuss her increasing anxiety and made no assessment of suicidal ideation. The August 27, 2015 chart notes comprise two lines, primarily reflecting that P-1 asked for a note releasing her to go back to work. It's not clear whether this was an office visit or a phone call.

16. On September 8, 2015, Respondent noted that P-1 called "panicky." Respondent did not document a mental status exam or an inquiry about suicidality. P-1 asked for Lamictal[10] 200

[9] Lexapro, a trade name for escitalopram, is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It is a dangerous drug as defined in section 4022.

[10] Lamictal, a trade name for lamotrigine, is an anticonvulsant or antiepileptic drug. It is used alone or with other medications to treat epileptic seizures in adults and children. Lamictal is

mg. Respondent wrote in parentheses that P-1 didn't tell him about the Lamictal. Respondent didn't chart having prescribed the Lamictal but it did become part of his treatment plan with Workers Compensation. Respondent did not document what purpose the Lamictal was prescribed for or how many tablets he prescribed and he never documented a discussion with P-1 about the purpose of the drug or the potential side effects. P-1 also asked for another prescription for Nuvigil, saying that she needed it because she had been breaking up the 250 mg tablets before he added the additional 50 mg. Respondent did not document the quantity of tablets prescribed or make it clear whether or not he called in the Nuvigil prescription.

17. On October 1, 2015, P-1 left a message seeking to refill Effexor 37.5 mg and Neurontin[11] 300 mg. Respondent wrote that he didn't have those down but that he would issue refills for them and then ask P-1 to update him regarding those refills. Respondent did not document the quantity of medications prescribed. On October 14, 2015, P-1 told Respondent that she was crying and very upset, apparently in response to her new job. Respondent wrote that P-1 said that she had never had a panic attack before, implying that she was having one then. P-1 told Respondent that she had been taking one of the Ativan tablets every few days before she threw out 50 tablets and stopped taking them altogether three weeks before the visit. P-1 asked for Xanax. The chart notes say that they decided to leave her off benzodiazepines. The CURES report, however, reflects that P-1 filled a prescription from Respondent for 90 Ativan tablets two weeks before the visit, a week after she claims to have quit, and filled a prescription from Respondent for five Xanax tablets the day before the visit. There is no record that Respondent had prescribed that Xanax for P-1. Respondent did not document a mental status exam or an inquiry about suicidality.

18. On October 16, 2015, P-1 made an emergency visit asking for Xanax. P-1 said she had not been taking Ativan and Respondent wrote "maybe can use Klonopin 1 tid." P-1 reported

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also used to delay mood episodes in adults with bipolar disorder. It is thought to work by restoring the balance of certain natural substances in the brain. Lamictal is a dangerous drug as defined in section 4022.

[11] Neurontin, a trade name for gabapentin, is a nerve pain medication and anticonvulsant. It is indicated for treatment of seizures and neuropathic pain caused by shingles. It is a CNS depressant. Gabapentin is a dangerous drug as defined in section 4022.

that she had doubled her Lexapro on her own and it had made her more anxious. P-1's heart was racing, chest heavy, and she had difficulty breathing. P-1 denied suicidal intent or ideation. P-1 said she had not taken Ambien in months although she had filled a prescription from Respondent only two days before. Respondent gave P-1 a prescription for 30 Ambien tablets plus two refills and 21 Klonopin[12] tablets to be taken 3 times a day. Respondent did not address P-1's non-compliance with her medications. Respondent asked P-1 to follow up by telephone in two days.

19. P-1 followed up six days later when she called to say that she had not taken Nuvigil for a week or so and that she thought that might be the problem. Respondent had never assessed what if any benefit the Nuvigil was providing. In response to P-1's request and without discussing the possibility that Nuvigil might be contributing to P-1's anxiety, Respondent called in a prescription for Nuvigil.

20. On November 6, 2015, P-1 asked for a refill of Effexor and Respondent gave it to her without discussion. On December 18, 2015, Respondent billed Workers Compensation for a half hour visit that allegedly occurred on November 16, 2015 but did not prepare chart notes for a visit on that date. On December 18, 2015, P-1 reported that she had received bad news regarding her health but did not want to talk about it. Respondent did not document having explored this issue with P-1 and did not contact her primary care physician. Nor, despite the panic and anxiety P-1 had been complaining about, did Respondent do an assessment of P-1's mental health. During the two-month period preceding this visit, CURES reports reflects that P-1 had received two

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[12] Klonopin, a trade name for clonazepam, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs.

prescriptions of hydrocodone, two of oxycodone,[13] three of buprenorphine[14], two of phenobarbital,[15] and two of carisoprodol[16] from other physicians.

21. The chart notes do not reflect visits between December 18, 2015 and March 9, 2016. On January 20, 2016, the pharmacy called for Nuvigil and Effexor for P-1, which Respondent refilled. On March 7, 2016, P-1 called Respondent for Lamictal 200 mg. Respondent wrote that he "didn't seem to have recorded this regularly; not clear why not but will refill now." Respondent did not document the quantity of tablets prescribed. Respondent did not reassess why he had initially prescribed the Lamictal or document a discussion with P-1 about her experience with the Lamictal, its benefits, or any side effects.

22. On March 9, 2016, P-1 reported that she had trouble getting to sleep, that she had nightmares, that some days she couldn't get out of bed in the morning, that nearly half of her days were "bad," and that some days she didn't know if she could work if she were to find a job. Respondent discussed antidepressants, writing that they had tried Wellbutrin and it had given P-1 three weeks of anxiety as had raising the dose of Effexor. Respondent had never documented a trial of Wellbutrin or that he had raised the dose of Effexor he was prescribing for P-1. Respondent did not mention doing a suicide assessment.

23. On P-1's next visit, April 14, 2016, she reported that her landlord had given her apartment to his nephew and she was living with friends and looking for a place to live. Respondent did not assess P-1's level of depression or do a suicide assessment. Respondent sent

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[13] Oxycodone is a short-acting opioid whose principal therapeutic action is analgesia. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code. It is a more potent pain reliever than morphine or hydrocodone.

[14] Buprenorphine is an opioid medication. It is a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined in section 11056 of the Health and Safety Code. Buprenorphine is used as a pain reliever and as part of drug addiction detoxification and maintenance programs.

[15] Phenobarbital is a barbiturate and nonselective central nervous system depressant which is primarily used as a sedative hypnotic and also as an anticonvulsant in subhypnotic doses. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[16] Carisoprodol, also known by the trade name Soma, is a muscle relaxant that blocks pain sensations between the nerves and the brain. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

a letter to Workers Compensation saying that P-1 was totally disabled and needed to continue on medical leave.

24. P-1 called for a refill of Effexor on April 20, 2016, called for a refill of Nuvigil on April 25, 2016, and, "with increasing anxiety," called for Klonopin up to twice a day on May 16, 2016. Respondent did not do a mental health assessment or assess P-1 for suicidality. Respondent did not document having prescribed the medications P-1 requested on these dates and, for the Effexor and the Klonopin, did not document quantities.

25. On May 26, 2016, P-1's psychotherapist called Respondent and told him of P-1's suicide. P-1 had hanged herself.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, and/or Failure to Maintain Adequate Records)

26. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to undertake an adequate assessment of Patient P-1 over the course of her treatment.

B. Respondent was unable to set limits on Patient P-1 and to remain in control of her treatment; he permitted her to direct her own treatment plan, failed to confront her non-compliance, failed to consult CURES or other providers despite P-1's request for various medications including a number of different benzodiazepines, and failed to direct the frequency of her treatment visits.

C. Respondent failed to, among other things, adequately diagnose Patient P-1 before initiating treatment, to obtain informed consent, to monitor P-1's treatment, to monitor potential suicidality, to properly chart prescriptions for medications, to chart all visits clearly, and/or to document when the next appointment was scheduled.

PATIENT P-2

27. Patient P-2 was 58 years old when Respondent assumed his care on April 4, 2013. P-2 remained in Respondent's care until August 20, 2017 when he stopped returning Respondent's calls after the Medical Board contacted him about his treatment. At his initial visit, P-2 complained of depression and feeling "down" for a long time, yet Respondent documented no history of his depressive feelings or prior treatment except to note that he had tried Zoloft.[17] There was no information about P-2's use of Zoloft. Although P-2 said that he thought about suicide, Respondent did not document any details about suicidal thoughts or history of suicidal thoughts or attempts and did not mention suicidality in any of P-2's subsequent visits. Respondent did not document inquiries about P-2's sleep, motivation, function at work or other activities of daily life. Respondent mentioned that P-2 said he used to drink a lot 25 years before but didn't offer any details and there was no discussion of any other substance abuse history. Respondent did not document whether or not P-2 had a family history of alcohol or substance abuse.

28. Respondent diagnosed P-2 with depression and social anxiety disorder although the only information documented about anxiety is from high school when, Respondent noted, P-2 began to notice that it wasn't easy to get along with non-family members. Respondent did not document a discussion of P-2's current anxiety symptoms. Although Respondent noted under social history, "[n]o alcohol or other drugs," he documented that P-2 was taking Xanax he had gotten from a friend. Respondent wrote that P-2 was "[a] little too eager for high doses of Xanax," and then prescribed Xanax, 2 mg twice a day—noting that he was limiting P-2 to that amount—and 10 mg of Lexapro. Respondent did not describe the specific reason for prescribing Xanax and did not document the number of tablets or number of refills. Respondent did not document how much Xanax P-2 had been taking, or for how long, or whether P-2 had ever been prescribed benzodiazepines by a medical professional. Respondent noted that P-2 was

[17] Zoloft, a trade name for sertraline, is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It is primarily used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, and PTSD. It is a dangerous drug as defined in section 4022.

"[p]robably also ADD [Attention Deficit Disorder]" but Respondent did not identify on what he based his ADD assessment. The only history Respondent documented regarding potential ADD is that P-2 had trouble with focus and concentration and a little hyperactivity. At the same time, Respondent described P-2 as having a "slow-moving demeanor." Respondent did not document P-2's current symptoms or childhood history of symptoms; his functioning at home, work, or school; behavioral disturbances; or other pertinent indications. Respondent did not question whether the symptoms that P-2 had described could have resulted from depression or anxiety.

29. Respondent documented that P-2 had chronic pain, obesity ("likely over 500 lbs"), and hypertension. Respondent noted that P-2 had tried Neurontin in connection with surgery, but not what the surgery was for, or when, or what the outcome of taking the Neurontin had been. Respondent listed an opiate-Tylenol medicine that P-2 was taking but did not identify it and did not discuss how long he had been taking it or if he had taken other opiate or benzodiazepine medications and did not check CURES or collaborate with other prescribers. In fact, Respondent did not check CURES once during the time he treated P-2. There is no documentation that Respondent discussed the risks and benefits of the medications he prescribed at the initial visit or their potential interactions with other medications, particularly benzodiazepines and opioids. Respondent did not document any blood pressure readings at this time or address any treatment P-2 was receiving for hypertension. Respondent did not consider pertinent negatives such as cardiac status before prescribing high doses of Xanax and, later, stimulant medication. Respondent documented an instruction to take "weekly vitals" but did not note any blood pressure readings until February 18, 2014 by which time P-2 had been on 60 mg of Adderall daily for 10 months. On February 18, 2014, Respondent prescribed Atenolol to P-2 for blood pressure.[18] P-2's chart did not reflect that he was on Atenolol or any blood pressure medication up until then. P-2 told Respondent that his blood pressure was 130/80. The only subsequent mentions of blood pressure were in May 2014 and December 2016. Respondent did not take P-

[18] Atenolol is a Beta-1-selective adrenergic antagonist, used to treat angina (chest pain) and high blood pressure. It is a dangerous drug as defined in section 4022.

2's blood pressure, consult with his primary care physician, or otherwise confirm his readings. Respondent never took or recorded P-2's pulse rate.

30. Two weeks after P-2's first visit, P-2 told Respondent that he didn't feel that 2 mg twice a day of Xanax was adequate and asked that it be doubled to 2 mg four times a day. Respondent wrote, "will compromise" and raised the amount to 2 mg three times a day. P-2 also said that he didn't want to continue on Lexapro and thought that a stimulant for the ADD might serve the same social function. While noting that "[w]e do have to worry that he's drug seeking," Respondent said he had no reason to think so and prescribed Adderall[19] 10 mg up to three times a day, writing, "will follow carefully." Respondent prescribed Adderall without diagnosing P-2 with ADD, without explaining how a stimulant would help social functioning in a person with social anxiety disorder, and without information about P-2's blood pressure or treatment of his hypertension.

31. On June 13, 2013, Respondent added half an Ambien tablet daily to P-2's regimen without any mention of sleep problems or giving a reason for prescribing the medication. A month later, Respondent increased the dosage to 1-1/2 tablets daily, again without explanation. On November 21, 2013, Respondent prescribed Valium[20] 10 mg daily to be taken at bedtime at P-2's request. P-2 wanted Valium because it was a longer-acting medication. Respondent did not express concern that P-2 knew that Valium was longer-acting or that he asked for a specific dosage. Respondent did not document his reason for acquiescing to P-2's request. On December 28, 2013, P-2 asked for Ambien again. On January 30, 2014, Respondent noted, without discussion of the propriety of doing so, that P-2 alternated Valium and Ambien. Respondent simply acceded to this practice.

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[19] Adderall is a trade name for a combination of amphetamine and dextroamphetamine, central nervous system stimulants that affect chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Adderall is used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy. Stimulants are known to have caused stroke, heart attack, and sudden death in people with high blood pressure, heart disease, or a heart defect. Adderall is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined in section 11055 of the Health and Safety Code.

[20] Valium, a trade name for diazepam, is a benzodiazepine. It is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

32. Although P-2's primary complaint at his first visit was depression and although he said he thought about suicide, Respondent did not mention depression or suicidal ideation in any of his chart notes thereafter.

33. On March 27, 2014, P-2 said he had been on Xanax four times a day for years and that three times a day "just doesn't do it." There was no record that P-2 had been on Xanax before starting treatment with Respondent other than what he got from a friend. Despite this and despite noting that P-2 had been "even keeled" and seemed to be doing well, Respondent increased the Xanax to 2 mg four times a day. Respondent did not consider the possibility that the stimulant Adderall may have been contributing to P-2's anxiety. On May 22, 2014, Respondent noted that P-2 was doing well, and without explanation, increased P-2's Adderall dose to 20 mg four times a day.

34. Respondent spent a number of visits attempting to negotiate lower doses of benzodiazepines with P-2. It appears that, although it isn't documented, P-2 had agreed at some point to stop taking Ambien. When the pharmacy called on October 9, 2014 for a refill of Ambien, Respondent called P-2 to remind him that that they had stopped the Ambien. P-2 offered to go back on Ambien and stop Valium. Respondent said "fine" and prescribed Ambien. A month later, P-2 asked for just 30 Valium tablets and Respondent wrote "So #30" and prescribed the Valium.

35. In November 2015, Respondent congratulated P-2 for reducing his Xanax to three times a day. Four months later, Respondent's chart notes say that he is reducing Xanax to three times a day. Two months after that, Respondent increased the Xanax to four times a day at P-2's request in exchange for reducing Ambien from 15 mg to 10 mg a day, noting, "I fuss as usual" but he felt risk was worth getting stable. A few months later, with no discussion of why, P-2 was back up to 15 mg of Ambien daily.

36. On March 7, 2016, Respondent spoke to a pharmacist who told him that P-2 had been refilling his Adderall six days early for months, resulting in his getting an extra month's worth of Adderall. There is no documentation that Respondent discussed this with P-2.

37. Respondent's last contact with P-2 as his physician was on August 17, 2017 when he called P-2 in response to concerns from the pharmacy about P-2's Xanax and Valium prescriptions. P-2 told Respondent that he panicked when the Medical Board contacted him about his care. Respondent tried reaching him again over the next several days but he did not answer the phone or return Respondent's messages.

38. Throughout Respondent's treatment of P-2, his chart notes often only consist of a list of medications prescribed and it is not clear if he saw P-2 on a particular day or only responded to a prescription request.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Incompetence, and/or Failure to Maintain Adequate Records)

39. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c) and/or (d), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to undertake an adequate assessment of Patient P-2 over the course of his treatment.

B. Respondent prescribed a high dose of Adderall for Patient P-2 with very little evidence that he had attention deficit disorder; failed to consider or discuss with P-2 the possibility that his difficulty with anxiety and sleep may have resulted from his stimulant use; failed to obtain an adequate cardiac history for P-2, an obese patient, before prescribing Adderall and to monitor his blood pressure and pulse rate during his treatment with Adderall; and failed to collaborate with other providers or check CURES to monitor P-2's compliance despite his having obtained a controlled substance from a friend and seeking specific controlled substances in specified amounts.

C. Respondent failed to document medical history to support his diagnoses of Patient P-2 and his medical decision-making; failed to assess whether P-2's anxiety and sleep

difficulties could be adverse effects of the Adderall he prescribed; failed to document discussions of the risks and benefits of prescribed drugs and potential drug interactions; failed to document monitoring treatment with follow-up evaluation of P-2's response to treatment; and failed to monitor P-2's depression and potential suicidality.

D. Respondent was unable to set limits on Patient P-2 and to remain in control of his treatment and failed to consult CURES or other providers despite P-2's requests for specific medications including two benzodiazepines, a stimulant, and a hypnotic.

E. Respondent failed to recognize the cross-reactivity of Xanax, Valium, and Ambien and that tolerance and addiction to one can lead to tolerance and addiction to the others.

F. Respondent failed to chart all medications prescribed complete with dose, directions, quantity, and number of refills.

PATIENT P-3

40. Patient P-3 was 29 years old when Respondent assumed his care on January 10, 2012. He remained in Respondent's care until July 20, 2017. At his initial visit, P-3 complained of anxiety and hives.

41. Respondent documented that P-3 had weighed 345 pounds, undergone gastric bypass surgery, and lost 110 pounds. Respondent did not note when the surgery took place or what P-3's current weight was. Respondent did not document how long P-3 had suffered from anxiety, what P-3 had tried to do to treat it, or how anxiety affected P-3's life, other than that talking to people caused P-3 to get hives and that his hives kept him from working out. P-3 reported that he did not use alcohol or drugs but that marijuana helped him to focus. P-3 said that he had difficulty focusing, that he had anxiety from not getting "stuff" done, and could focus only on video games. P-3 said he spent all his time on the couch and slept only three hours per night. Except for recording that P-3 had undergone bypass surgery and had Bell's Palsy in the last year, Respondent did not document any past medical history and did not address P-3's bypass surgery, cardiac status, or blood pressure. The chart notes include no past psychiatric history or information about P-3's childhood or adult life, attention, concentration, executive functions, how he did in school, why he quit school, or past behavioral issues.

42. Respondent diagnosed P-3 with ADD, social anxiety disorder, mood disorder, quasi-addiction to video games, and anxiety disorder (questioning whether he had agoraphobia and/or generalized anxiety disorder). Respondent's plan was to prescribe Celexa[21] 20 mg to go to 40 mg and Adderall 10 mg to go to three times a day. Respondent did not document discussing other treatment options with P-3 such as psychotherapy, did not document informing P-3 that Adderall could make his anxiety and sleep problems worse, or obtain informed consent, and did not discuss how to monitor side effects in a post-gastric bypass patient who will be taking two medications. Respondent did not check P-3's blood pressure or cardiovascular status before prescribing the stimulant Adderall and did not document a plan to monitor his blood pressure. Respondent did not list the number of tablets prescribed or whether there were refills and gave P-3 a range of dosages of both medications without describing how he was to determine when to increase the dose. Respondent did not identify a date for a return visit. In fact, the next visit wasn't until seven months later.

43. The chart notes for the next visit on August 14, 2012 do not explain the seven-month hiatus. Respondent noted that P-3 had done well with Adderall 10 mg three times a day in the past without making clear whether he was referring to the period since his last visit or some prior time. Respondent did not document any information on how the Adderall had benefitted P-3, how it had affected his attention, concentration, executive functioning, or behavior or whether there were side effects. There was no mention of P-3's anxiety and no reference to Celexa. Respondent prescribed a one-month supply of Adderall 10 mg to be taken three times a day. No return date was documented.

44. P-3's next visit was four months later, December 6, 2012, again with no explanation for the hiatus. Respondent did not question whether P-3 was taking Adderall during the period he was not seeing him and, if he were, where he was getting it. Respondent did not check CURES to see if he had been getting it from other prescribers or document any attempt to consult with P-3's other providers. Because P-3 said that he felt dopey and slow when he ran out of Adderall, and

[21] Celexa, a trade name for citalopram, is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors. It is primarily used to treat depression. It is a dangerous drug as defined in section 4022.

felt that his current dose was getting less effective and shorter acting, Respondent doubled the dose. Although P-3 complained of general anxiety around people and had earlier complained of sleeping only 3 hours a night, Respondent did not advise him of the possibility of increased anxiety from Adderall or of Adderall's effect on sleep. P-3 reported that his blood pressure was less than 120/70 when he remembered to check it but not did say how often he remembered to check it or when he had last checked it and did not provide specific numbers. Because P-3 said he had tried Celexa once—Respondent did not indicate that he recognized having prescribed it to P-3 himself—and it didn't seem to help with his anxiety around people, Respondent added two new drugs for anxiety, Luvox[22] 50 to 100 mg and Neurontin 300 mg. Respondent did not document having obtained informed consent or having addressed dosage titration. There is no further mention of Luvox in Respondent's chart notes for P-3 and there is no further mention of Neurontin until July 22, 2015 when P-3 reported that his aunt gave him Neurontin for a panic attack and Respondent then prescribed Neurontin 300 mg to be taken twice a day with the hope that they would be able to lower Adderall or Ativan. Ativan had not previously been documented as a drug P-3 was taking.

45. P-3's next visit was March 13, 2013, three months later. For the following 11 months, there were entries approximately every two months that appear to reflect that P-3 or his wife had called in for or picked up prescriptions. The next entry that appears to be for an actual visit by P-3 is on February 18, 2014, following an 11-month hiatus.

46. On February 18, 2014, P-3 reported that he had raised his Adderall dose on his own to 30 mg three times a day, an increase of 50%. P-3 said it calmed him but also reported increased anxiety and asked for Xanax 1 mg up to twice a day. Respondent adopted P-3's increased Adderall dosage and acceded to his request for Xanax without obtaining informed consent. Although Respondent told P-3 to take his blood pressure each time he filled a prescription for Adderall and report the number to him, there are no documented blood pressure readings for the

[22] Luvox, a trade name for fluvoxamine, is a selective serotonin reuptake inhibitor antidepressant. Luvox is used to treat social anxiety disorder (social phobia) or obsessive-compulsive disorders involving recurring thoughts or actions. Luvox inhibits the metabolism of caffeine and can contribute to anxiety and sleeplessness if caffeine is used while taking Luvox. It is a dangerous drug as defined in section 4022.

three plus years he continued to prescribe Adderall. Despite P-3's asking for a specific brand and dosage of benzodiazepine, Respondent did not ask P-3 about his experience with benzodiazepines or check CURES or consult with other providers to investigate his benzodiazepine use.

47. On November 6, 2014, Respondent added Lexapro 10 mg to P-3's regimen.

48. On March 26, 2015, Respondent documented that P-3 described having symptoms that sounded like Rapid Eye Movement (REM) intrusions. Respondent did not describe what the symptoms were or mention the possibility that they might be hallucinations and might relate to the dose of Adderall. There are no further references to REM intrusions in Respondent's subsequent chart notes for P-3.

49. On the March 26, 2015 visit, Respondent wrote that P-3 told him he hadn't taken Xanax for a month and that Respondent advised P-3 that he didn't want to give Xanax to him anymore. Two weeks later, P-3 came in specifically for Xanax, saying that he actually had been taking it, even though he had previously stated he had not been taking it.

50. Over time, there is deterioration in P-3's social relationships. Marital discord and separation are documented. On October 19, 2015, Respondent documented that P-3 had been written up at work for soliciting drugs.

51. On May 12, 2016, P-3 complained that the Adderall was "wearing off," so Respondent replaced one Adderall dose with Ritalin.[23] Respondent discontinued the Ritalin a month later noting that Adderall seemed better once again.

52. On June 13, 2016, P-3 reported that he was being singled out at work for criticism and was being monitored. P-3 said that he had always had issues with management, that they had told him he was not engaged enough, and it seemed they had decided he was not sociable and labelled him a drug addict. Despite this, Respondent did not discuss possible improper drug use with P-3 and did not check CURES or consult with his other providers.

[23] Ritalin, a trade name for methylphenidate, is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Ritalin is used to treat attention deficit disorder, attention deficit hyperactivity disorder, and narcolepsy. Ritalin is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined in section 11055 of the Health and Safety Code.

53. On July 29, 2016, P-3 told Respondent that he had been on 40 to 50 mg a day of Norco 10 mg and his primary care physician had "cold turkey'd" him. Respondent did not discuss why or for how long P-3 had been on opiates. Respondent did not consider the possibility that the opiates and Adderall may have contributed to the deterioration of P-3's behavior; did not consider modifying his dose of Adderall; did not consult with his primary care physician; and did not check CURES. P-3 reported that work was getting more stressful and the new manager was harassing him. Respondent wrote a note for P-3 to take a leave of absence. It appears from Respondent's chart notes that P-3 was off work most of the following year.

54. On May 8, 2017, Respondent once again prescribed Celexa 20 mg for P-3 to be taken up to 2 times a day. Respondent did not document the reason for prescribing the Celexa, did not mention that he had prescribed it previously, and discontinued it at the next visit because P-3 said it caused headaches.

55. On June 28, 2017, Respondent told P-3 that he could have two more months of Adderall, then he would have to find another doctor. Respondent did not document any explanation of why he was terminating P-3.

56. After Respondent moved to Minnesota, he found out that P-3 had forged a letter purporting to be from Respondent. When P-3 asked Respondent to cover for him, Respondent refused.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

57. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) and/or (c), section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or prescribed excessive amounts of a controlled substance and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to undertake an adequate assessment of Patient P-3 over the course of his treatment.

B. Respondent prescribed a high dose of Adderall for Patient P-3 with very little evidence that he had attention deficit disorder; failed to consider or discuss with P-3 the possibility that his difficulty with anxiety and sleep may have resulted from his stimulant use; failed to obtain an adequate cardiac history for P-3—a possibly obese patient who had had gastric bypass surgery—before prescribing Adderall; failed to monitor his blood pressure and pulse rate during his treatment with Adderall; and failed to collaborate with other providers or check CURES to monitor P-3's compliance despite, among other things, his seeking a specific controlled substance in a specified amount, his being labeled a drug addict at his place of employment, and his revealing after years of treatment that his primary care physician had been prescribing opioid medication for him.

C. Respondent failed to document medical history to support his diagnoses of Patient P-3 and his medical decision-making; failed to assess whether P-3's anxiety and sleep difficulties could be adverse effects of the Adderall he prescribed; failed to document discussions of the risks and benefits of prescribed drugs and potential drug interactions; failed to document monitoring treatment with follow-up evaluation of P-3's response to treatment.

D. Respondent was unable to set limits on Patient P-3 and to remain in control of his treatment, permitting him, among other things, to leave long periods between visits and increase his dose of Adderall on his own dramatically and acceding to his specific request for Xanax.

E. Respondent failed to chart all medications prescribed complete with dose, directions, quantity, and number of refills.

PATIENT P-4

58. Patient P-4 was 26 years old when Respondent assumed his care on January 27, 2006. P-4 remained in Respondent's care until at least March 20, 2018. The notes for P-4's initial visit are for the most part illegible but it appears that he complained of anxiety and not being able to study and that Respondent gave a diagnosis of ADD. Respondent prescribed Neurontin 300 mg

up to 600 mg and Trileptal[24] 150 mg up to 450 mg. Respondent prescribed Neurontin throughout the entire time he treated P-4 and Trileptal through the end of 2016 or 2017. Respondent did not identify why he was prescribing either of these medications, although it may be inferred that the Neurontin was to treat anxiety. Respondent never explained the reason for prescribing Trileptal. Respondent did not document having discussed the potential risks and benefits of taking these medications at this initial visit or in any subsequent chart note even though Trileptal carries a risk of such serious side effects as electrolyte abnormalities and severe rash including Stevens Johnson Syndrome which has rare life-threatening potential.

59. At no point in his treatment of P-4 did Respondent document P-4's weight or vital signs. Although his initial notes are mostly illegible, it appears that he didn't discuss P-4's past psychiatric, childhood, social, family, medical, drug, or alcohol abuse history.[25] Respondent also failed to document discussions of these matters in subsequent notes and never conducted a mental status examination. Respondent did not document any contact with or even the name of P-4's primary care physician. Respondent never checked CURES.

60. On February 3, 2006, P-4 advised Respondent that he wanted to target ADD, learning and keeping focus. Respondent did not document anything beyond this to support a diagnosis of ADD. Respondent added dextroamphetamine,[26] one of the most powerful of the stimulants used to treat ADD, to P-4's medications at the high dose of 10 mg three times a day. Neither at this time nor at any subsequent visit did Respondent document informing P-4 that dextroamphetamine could make his anxiety worse or informing him of the risks and benefits of

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[24] Trileptal, a trade name for oxcarbazepine, is an anticonvulsant or antiepileptic medicine. Trileptal is used either alone or with other medicines to treat partial seizures. It is also used off-label to treat some mood disorders such as bipolar disorder. It works by decreasing nerve impulses that cause seizures and pain. It is a dangerous drug as defined in section 4022.

[25] Respondent did make some reference to alcohol in his initial, mostly illegible chart notes; wrote "etoh+meds" in November 2007; and noted that P-4 had been a "crazy alcoholic" when he was 17 and that he was overdrinking in June 2009.

[26] Dextroamphetamine, also known by the trade names Dexedrine (short-acting) and Dexedrine Spansule (extended release), is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Dextroamphetamine is more powerful than most other medications used to treat narcolepsy and ADHD including Adderall, Ritalin, and Vyvanse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined in section 11055 of the Health and Safety Code.

the drug. Respondent did not check P-4's blood pressure or cardiovascular status before prescribing the stimulant dextroamphetamine or at any subsequent time and did not document a plan to monitor his blood pressure. Respondent increased the dosage over the next months and years. By September 2008, P-4 was getting 90 mg of dextroamphetamine daily, 30 mg three times a day, and by January 2009, without explanation, Respondent increased Vyvanse[27] from 30 mg to 90 mg daily. Respondent documented a Vyvanse dose of 70 mg a day in March 2009 and then never mentioned Vyvanse in P-4's chart notes again. In February 2011, with no explanation, Respondent increased the dosage of dextroamphetamine to 120 mg, 30 mg four times a day, the level at which it remained throughout the rest of the time he treated P-4.[28]

61. In January 2012, P-4 was having difficulty finding enough dextroamphetamine at pharmacies and Respondent switched him to Dexedrine Spansules[29] 30 mg four times a day and Adderall 30 mg four times a day in case P-4 couldn't get the Dexedrine Spansules. In May 2012, P-4 said he was feeling despair. The chart notes are mostly illegible but say that Respondent stopped Celexa because of sleep problems and that Respondent added a different antidepressant. P-4 was directed to return in one month but his next visit was four months later on September 18, 2012. P-4 had failed to start the antidepressant, reduced the dose of Dexedrine because of fear of supply problems, and lost 35 pounds. Respondent did not discuss the lapse of time, P-4's decision to reduce his Dexedrine dosage on his own, or explore the reasons for the dramatic weight loss. Respondent gave P-4 a sample of a different antidepressant, Cymbalta,[30] and told him they should talk in two weeks. The next visit was six months later in March 2013 with no explanation for the hiatus. At that visit P-4 described losing it, breaking things, feeling isolated and cut off, being paranoid about the possibility of not getting Dexedrine, feeling more anxiety,

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[27] Vyvanse, a trade name for lisdexamfetamine, is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is FDA-approved to treat ADHD. Vyvanse is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined in section 11055 of the Health and Safety Code.

[28] Respondent changed the dosing on July 9, 2012 to 60 mg two times a day instead of 30 mg four times a day with no explanation.

[29] Dexedrine Spansule is a trade name for extended release dextroamphetamine, a central nervous system stimulant described in footnote 26, above.

[30] Cymbalta, a trade name for duloxetine, is a selective serotonin and norepinephrine reuptake inhibitor. It is used to treat depression and anxiety. Duloxetine is a dangerous drug as defined in section 4022.

feeling awful about himself when he was not taking the Dexedrine Spansules, and being in a downward spiral. P-4 said that everything was a project, even simple things like parking a car or ordering coffee. Respondent did not reassess his treatment of P-4, continuing to prescribe 120 mg of Dexedrine Spansules daily. Respondent did not consider whether Dexedrine tolerance, addiction, or amphetamine psychosis could be the cause of the deterioration. Respondent said that P-4 did not get the Cymbalta he prescribed at the last visit because P-4 would not do the paperwork. Respondent prescribed Luvox, the fourth antidepressant he prescribed for P-4, and directed P-4 to schedule monthly meetings with him. It appears from the chart notes that their next interaction was what Respondent described as an extended discussion about stress by telephone seven months later in conjunction with P-4's request for a note from Respondent for a one-month "stress leave." Respondent did not mention any details of P-4's stress or his response to treatment. P-4's next actual visit was a month after that. Respondent did not comment on the unexplained hiatus.

62. In November 2013, P-4 was still on stress leave and described paranoid feelings about being harassed at work saying that he got "absolutely stressed" just thinking about it. Respondent appeared to accept P-4's complaints at face value. By March 2014, P-4 was back at work and feeling very good about it, describing himself as one of the four people running the county. Two months later, however, P-4 was beginning to be upset with his job again and in September 2014, he told Respondent that "his work still sucked." In November 2014, P-4 described feeling really good and said that he expected a promotion soon but by May 2015, he was once again miserable and paranoid about work. P-4 did not get the promotion he wanted and blamed others, saying he had been "shafted," and that his co-workers had isolated him because he was so good at his job. Respondent's first note questioning the possible contribution of Dexedrine to P-4's anger and paranoia was on May 21, 2015. Respondent wrote that P-4 seemed to be having intrusions of issues that bothered him and questioned if he were having a depressive episode. Respondent queried whether Dexedrine were making P-4 more paranoid and asked him if he was more or less sensitive on Dexedrine. P-4 said he was not more sensitive and contended that he had not been angry since starting it nine years before. Respondent did not consider or document the possibility

that P-4's response might be a product of poor judgment and insight but took it at face value, left his medications as they were, and recommended another month of leave.

63. P-4's next visit was June 17, 2015. They discussed P-4's roommate's belief that P-4 was bipolar. Respondent noted that he agreed with the diagnosis. Respondent did not document, and had not documented, a past history of bipolar symptoms, did not document a mental status exam to demonstrate manic presentation, never mentioned an assessment for suicidality or dangerousness with his anger and paranoia, and did not reassess his prescribing stimulants and antidepressants with the emergence of possible mania. P-4 said that he was a mess, agitated, depressed, and paranoid. Instead of modifying the stimulant, Respondent added lithium, Lithobid[31] 300 mg "after labs," advising him that he could go up to three times a day unless there were side effects. Respondent did not document advising P-4 of what the side effects might be or how P-4 should determine whether to increase his dose to more than once a day. Respondent did not discuss the symptoms of lithium toxicity, how to handle salt loss, potential interactions with NSAIDS or alcohol, or the need for routine monitoring of thyroid and renal function and lithium level. Although it appears that P-4 never had the laboratory tests done, Respondent continued to prescribe Lithobid for him throughout the rest of the time he treated him. Respondent never documented ordering or obtaining a lithium level or an assessment of P-4's thyroid function. In July 2015, P-4 described his return to work as a debacle stating that he was extremely frustrated and anxious, and that he couldn't stay there. Respondent recommended another two month leave of absence.

64. In September 2015, P-4 asked Respondent for a physician's certificate for leave but wanted him to avoid attributing his condition to work because he did not want to file a worker's compensation claim. Respondent gave P-4 a December 1, 2015 back to work date and noted that he needed to keep vigilant to make sure that P-4's responses were not paranoid and being made worse by stimulant medication. Despite these concerns and P-4's deterioration, Respondent did

[31] Lithobid is a trade name for lithium carbonate. Lithobid is indicated in the treatment of manic episodes of Bipolar Disorder and as a maintenance treatment for individuals with a diagnosis of Bipolar Disorder. Maintenance therapy reduces the frequency of manic episodes and diminishes the intensity of those episodes, which may occur. It is a dangerous drug as defined in section 4022.

not see P-4 again until March 2016, 7-1/2 months after his previous visit, and continued prescribing Dexedrine during this unexplained hiatus.

65. At the March 2016 visit, P-4 reported that after a bad report at work, he hid in his room and tried to kill himself by taking "a bunch of meds." Respondent also documented that P-4 had been drinking and that he had apparently stopped all his medications. It is not clear from the chart notes exactly when this happened. Despite the suicide attempt, Respondent did not investigate P-4's current suicidal ideation. Respondent received a report from a psychiatrist who had apparently assessed P-4 at the behest of his employer and put him on leave for two months, which described P-4 as being unfit for work, not attending meetings, raising his voice, and doing unsociable things. P-4 denied all of it and said that the workplace and union were corrupt.

66. The next entry is six weeks later on April 27, 2016, and it is not clear whether it reflects a visit or something else; it simply lists several "[s]tatements made that [P-4] says not true," that P-4 was rude; brushed people off when he came to work in July 2015; and that he was outside pacing around talking to himself. Respondent apparently met with P-4 and his roommate a few days later but made no notes. The next visit is nearly six and a half months later on November 14, 2016. P-4 was apparently back at work and complaining that he had been put in a basement and about disciplinary action, being placed on maximum suspension based on made-up information. P-4 said that he was appealing the suspension. Respondent did not comment on the lengthy period between visits and did not document any assessment of P-4 or evaluation of his treatment.

67. Eleven months passed before P-4's next visit, on November 12, 2017. Although P-4 did not schedule a visit for 11 months, Respondent continued to prescribe for him. P-4 said that work was going well but that he was still not progressing with his social life. P-4 reported that he felt as if his highs and lows were smoothed by lithium. Respondent told him to return in two months.

68. Although there were several phone calls for prescriptions over the next several months, the next chart note that appears to reflect a visit with P-4 is five months later on March

18, 2018. Respondent did not discuss P-4's failure to comply with his instruction to return in two months and did not reassess his treatment plan for P-4.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing, and/or Failure to Maintain Adequate Records)

69. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) and/or (c), section 725, and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or prescribed excessive amounts of a controlled substance and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to undertake an adequate assessment of Patient P-4 over the course of his treatment.

B. Respondent prescribed and continued to prescribe a high dose of the very powerful stimulant dextroamphetamine throughout the time he treated Patient P-4 with very little evidence that he had attention deficit disorder; failed to consider or discuss with P-4 the possibility that his difficulty with anxiety may have resulted from his stimulant use; failed to document obtaining informed consent regarding side effects and addiction potential of dextroamphetamine; failed to obtain an adequate cardiac history for P-4 before prescribing dextroamphetamine and to monitor his blood pressure and pulse rate during his treatment with dextroamphetamine; and failed to collaborate with other providers or check CURES to monitor P-4's compliance

C. Respondent failed to document medical history to support his diagnoses of ADD and Bipolar Disorder for Patient P-4; failed to document his medical decision-making; failed to document a reason for prescribing Trileptal for P-4; failed to assess whether P-4's anger, anxiety, paranoia, and other symptoms could have been adverse effects of the dextroamphetamine Respondent prescribed; failed to document discussions of the risks and benefits of Lithobid and other prescribed drugs and potential drug interactions; failed to document monitoring treatment

with follow-up evaluation of P-4's response to treatment; failed to ensure and monitor necessary laboratory testing when prescribing lithium for P-4; failed to monitor potential suicidality in a patient who was variably despondent, labile, angry, paranoid, and had made a suicide attempt.

D. Respondent was unable to set limits on Patient P-4 and to remain in control of his treatment, permitting him, among other things, to leave long periods between visits and decrease his dose of dextroamphetamine periodically on his own.

DISCIPLINARY CONSIDERATIONS

70. To determine the degree of discipline, if any, to be imposed on Respondent Andrew Michael Abarbanel, M.D., Complainant alleges that on October 28, 2011, in a prior disciplinary action entitled In the Matter of the Accusation Against Andrew Abarbanel, M.D. before the Medical Board of California, in Case Number 03-2009-201966, Respondent's license was placed on probation for three years and Respondent was required to complete a number of educational requirements in resolution of allegations that, among other things, he prescribed controlled substances for patients without sufficient justification, failed to obtain informed consent from several patients for whom he was prescribing controlled substances, and failed to maintain adequate medical records. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 47490, issued to Respondent;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, 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: September 26, 2019

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