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

In the Matter of the Accusation Against: **Robert M. Littman, M.D.** 6386 Alvarado Court, Suite 210 San Diego, CA 92120 **Physician's and Surgeon's Certificate No. G 39129,** Respondent.	Case No. 800-2017-036131 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 16, 1979, the Medical Board issued Physician's and Surgeon's Certificate No. G 39129 to Robert M. Littman, 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 March 31, 2019, unless renewed.

JURISDICTION

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

4. 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."

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

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

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7. Section 2234 of the Code, states in part:

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

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

"(b) Gross negligence.

"(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.

8. 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 drug

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."

9. 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."

10. 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, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

11. Section 11165.1 of the Health and Safety Code states:

"(a)(1)(a)(i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that

practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP)."

PERTINENT DRUGS

12. **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. The DEA has identified amphetamines, such as Adderall, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

13. **Carisoprodol** (Soma®), a Schedule IV controlled substance, is a muscle relaxer with sedating effects primarily used to treat muscle pain. It is an addictive substance and may cause withdrawal symptoms.

14. **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 benzodiazapines, 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. The DEA has identified benzodiazepines, such as clonazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

15. **Cogentin**, a benztropine, is used to treat symptoms of Parkinson's disease or involuntary tremors due to the side effects of certain psychiatric drugs.

16. **Lorazepam**, a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of lorazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as lorazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

17. **Mirtazapine** is the generic name for Remeron®. It is an antidepressant used to treat major depressive disorder. It is a dangerous drug as defined in section 4022.

18. **Olanzapine** (Zyprexa®) is an antipsychotic used to treat mental disorders, including schizophrenia and bipolar disorder.

19. **Oxycodone** HCL (OxyContin®) is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The DEA has identified oxycodone as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2017 Edition), at p. 47.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

20. **Robaxin** is a muscle relaxer primarily used to treat muscle pain.

21. **Seroquel**, an antipsychotic, can be used to treat schizophrenia, bipolar disorder, depression, as well as insomnia.

22. **Temazepam**, a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.

Concomitant use of temazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as temazepam, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

23. **Trazodone hydrochloride** is a triazolopyridine derivative antidepressant. It is a dangerous drug as defined in section 4022.

24. **Vicodin®,** a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat pain and anxiety. It has a high risk for addiction and dependence and can cause respiratory distress and death when taken in high doses or when combined with other substances. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Vicodin, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

25. **Zolpidem** (Ambien®), a Schedule IV controlled substance, is a sedative primarily used to treat insomnia. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

26. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of a patient[1] (Patient), as more particularly alleged hereinafter:

27. According to Respondent's certified medical records[2], Respondent, a psychiatrist, first started treating Patient, a then-57-year old female, on or about February 8, 2012. Respondent listed Patient's primary complaints as major depression and generalized anxiety. Respondent diagnosed Patient with major depression. He noted that she had no history of alcohol or

[1] The patient is designated in this document as Patient to protect her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

[2] Patient's medical records are handwritten and illegible in parts.

substance abuse, and took Vicodin and Robaxin as needed. Respondent noted that Patient had increased agoraphobia, had been unemployed for the past 10 years, slept just 2-3 hours each night, and lost 20 pounds over the past year. Under family history, it is recorded that Patient's mother has major depression, her sibling suffers from bipolar disorder, and her cousin committed suicide.[3] Respondent did not refer Patient for psychotherapy. Respondent did not request copies of her previous medical records or consult with her treating physicians. Respondent started Patient on clonazepam 1 mg #90[4] and Adderall 20 mg #60. Respondent did not initially start Patient with an antidepressant, and indicated that Patient had "bad luck" with the numerous antidepressants she has taken in the past, but did not document which antidepressants Patient had previously taken, nor the dose or length of time. Respondent indicated that Adderall was being prescribed primarily for depression. Respondent did not check CURES for Patient's prior prescriptions, which included hydrocodone, zolpidem, carisoprodol, lorazepam, and clonazepam, all filled within weeks of Patient's initial office visit with Respondent. Respondent did not measure Patient's height or weight, or measure her blood pressure or heart rate. There is no record that Respondent discussed the side effects of Adderall or clonazepam with Patient.

28. On or about March 5, 2012, Patient had her second office visit with Respondent, where he noted that she had an "excellent response" to Adderall 20 mg and clonazepam 1 mg at three times per day. Respondent prescribed a 2-month supply of Adderall 20 mg #180 and clonazepam 1 mg #180. Patient had also received a prescription for clonazepam 1 mg #60 from another physician just three days before this appointment.

29. On or about April 17, 2012, there is a subsequent office visit, where Respondent noted that Patient was having persistent sleep disruption and her medication is well tolerated. He started her on temazepam 15 mg #60, 1-2 pills at bedtime, and continued Adderall at a dosage rate of 40 mg in the morning, and 20 mg in the evening, which is the maximum recommended daily dosage of Adderall. Respondent scheduled a return visit in 1-2 months. Per CURES,

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[3] Patient's family history suggests the possibility of bipolar disorder and suggests a strong family history of serious mood disorder. There is no indication that Respondent considered bipolar disorder.

[4] The starting dose of clonazepam is generally 0.5 mg/day. Respondent starts Patient at the maximum dose, which is 3-6 times higher than the recommended starting dose.

Patient filled the clonazepam prescription that same day, then filled another clonazepam prescription 18 days later, indicating that she was taking a significantly higher dose than prescribed by Respondent. Respondent did not document whether he provided Patient with refills and indicated that he ordinarily does not document refills in patient records when a patient calls for a requested refill.

30. On or about June 11, 2012, Patient is seen by Respondent following a hospital visit where she suffered fractured ribs, a pleural effusion, and a pneumothorax from an apparent fall.[5] She was started on Seroquel XR 50 mg by her primary care physician (PCP). It is noted that she had a decreased appetite and severe anxiety. There was no inquiry as to how Patient fell, her persistent insomnia, or an attempt to contact her PCP to discuss the reason Seroquel was prescribed or the causation of her injury. Had Respondent obtained Patient's hospital records from her fall, he would have learned that there were several times that Patient was found unarousable during admission to the hospital, and hospital staff believed she was abusing her prescription medication. Respondent quadrupled Patient's dosage of Seroquel to 200 mg per day, continued temazepam, continued Adderall 60 mg per day, and raised clonazepam to 1-2 mg three times per day. The next day, Patient filled the prescription for clonazepam 1 mg #360 and Adderall 20 mg #180. Patient's dosage of clonazepam had nearly doubled since her initial office visit approximately four months earlier.

31. On or about July 26, 2012, Respondent notes for Patient's visit that she has experienced weight loss since breaking her ribs and has persistent insomnia. He starts mirtazapine 15-30 mg at bedtime. He continues Patient with clonazepam 1-2 mg three times per day #360, Adderall 60 mg per day, and Seroquel XR 50-200 mg before bedtime. Respondent indicated that 60 mg of Adderall is a "good dose" for patient's size and weight, even though neither was documented in Patient's chart.[6]

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[5] Falls present an increased risk with high doses of benzodiazepines and/or sedatives.

[6] According to Patient's autopsy report, she was 65.5 inches and weighed 118 pounds at the time of her death. She was on the low end of normal for body weight, yet was prescribed the maximum daily dosage of Adderall by Respondent.

32. On or about September 3, 2012, Respondent noted that Patient was still underweight with persistent insomnia. Respondent added Cogentin 1-2 mg three time per day and Zyprexa 5-10 mg as necessary, started trazodone 50-100 mg daily and mirtazapine 15-30 mg before bedtime, continued Adderall 60 mg per day, and discontinued Seroquel XR. Clonazepam was not mentioned, but another prescription of 1mg #360 was given to Patient. Respondent indicated that Patient had stopped Seroquel on her own, but did not document the reasons. Patient has been started on three new medications at this visit after being recently hospitalized for broken ribs from a fall. A follow-up visit was not scheduled for 1-2 months.

33. On or about October 5, 2012, Patient had her last office visit with Respondent. Respondent noted that she had improved, the "meds are well tolerated," and to return in two months. He continued her medications without change. That same day, Patient filled a prescription written by Respondent for clonazepam 2 mg #150.

34. Patient was found dead in her home on or about November 5, 2012. The official cause of death was listed as "carisoprodol, lorazepam, oxycodone, zolpidem, and trazodone toxicity" with "coronary artery atherosclerosis" listed as a contributing condition. Amphetamines and clonazepam were also detected. Patient's friend was interviewed following her death, who reported that Patient had a history of overmedicating, her speech was often slurred, and she had sustained multiple falls. In June 2011, Patient had been appointed a county caretaker because of multiple falls, chronic pain issues, and bipolar disorder.

35. Patient's CURES indicates that she was on high dosages of prescription benzodiazepines and opiates since January 2009 through her death, and that she received these prescriptions from multiple physicians concurrently, or "doctor shopped." While she was a patient of Respondent, she was also receiving prescriptions on a regular basis for hydrocodone, oxycodone, lorazepam, Zolpidem, carisoprodol, and clonazepam from numerous other physicians, and filling these prescriptions at numerous pharmacies.

36. In an interview on or about September 19, 2018, Respondent indicated that he does not conduct drug toxicology screenings on patients because the clinical interview at a patient's first appointment provides him with all the information he needs. Respondent reported that he

now checks CURES regularly, but only for the past several months. He did not check CURES at any time for Patient. He reported that he has yet to register with CURES. Respondent did not consider tapering back Adderall despite Patient's persistent sleep problems and weight loss. When asked if he would have done anything different in regards to his treatment of Patient, Respondent stated, "Not that I can recall."

37. Respondent committed gross negligence in his care and treatment of Patient which included, but was not limited to, the following:

(a) Respondent failed to obtain records or speak with Patient's treating physicians following her hospital admission for fractured ribs, a pleural effusion, and a pneumothorax resulting from a sustained fall;

(b) Respondent prescribed Adderall to a new patient diagnosed with major depression;

(c) Respondent failed to document and monitor refill prescriptions, including telephone refills, and include prescriptions with the patient chart;

(d) Respondent failed to carefully monitor Patient's use of controlled substances to ensure she did not overuse or abuse the medications; and

(e) Respondent started Patient on multiple sedating medications at once without close monitoring.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

38. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient, as more particularly alleged herein.

39. Respondent committed repeated negligent acts in his care and treatment of Patient which included, but was not limited to, the following:

(a) Paragraphs 26 through 37, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to document the details of Patient's previous medication trials, including name of medication, dosage, duration, benefit and side effects, and reason for discontinuation;

(c) Respondent failed to communicate with or obtain records from Patient's other treating physicians at the beginning of treatment;

(d) Respondent started a new patient on a high dose of clonazepam rather than the lowest dosage needed to stabilize the patient;

(e) Respondent failed to refer Patient to psychotherapy or other methods of therapy, and instead treated Patient with medication alone;

(f) Respondent fails to document Patient's progress in a detailed, quantitative way;

(g) Respondent failed to monitor Patient's weight, heart rate, and blood pressure while prescribing Adderall;

(h) Respondent produced illegible medical records for Patient; and

(i) Respondent failed to learn from his clinical errors regarding his treatment of Patient.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

40. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs to Patient, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 26 through 39, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

41. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient, as more particularly alleged in paragraphs 26

through 40, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Register for CURES)

42. Respondent is further subject to disciplinary action under section 11165.1, subdivision (a)(1)(a)(i), of the Health and Safety Code, in that he failed to register for CURES as required for a health care practitioner, as more particularly alleged in paragraphs 26 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination and Medical Indication)

43. Respondent is further subject to disciplinary action under section 2242, subdivision (a), of the Code, in that he prescribed dangerous drugs without an appropriate prior examination and a medical indication, as more particularly alleged in paragraphs 26 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 39129, issued to Robert M. Littman, M.D.;

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

3. Ordering Robert M. Littman, 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:
November 8, 2018

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

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