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

In the Matter of the Accusation Against:	Case No. 800-2018-042810
IHOR ANTON MICHAEL GALARNYK, M.D. **72440 Morningstar Rd.** **Rancho Mirage, CA 92270** **Physician's and Surgeon's Certificate No. G 62655,** Respondent.	**A C C U S A T I O N**

PARTIES

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

2. On or about April 18, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number G 62655 to IHOR ANTON MICHAEL GALARNYK, 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 January 31, 2022, 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.

STATUTORY PROVISIONS

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:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2242 of the Code, states:

> (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.
>
> (b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or

furnished, any of the following applies:

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

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

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

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

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

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

7. 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.

8. Section 2266 of the Code states:

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

9. Health and Safety Code section 11165.4, subdivision (a) states, in pertinent part:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

DEFINITIONS

"Acamprosate" is a medication used to treat alcoholism by reducing the desire to drink alcohol. It is a dangerous drug as defined in Business and Professions code section 4022.

"Acetaminophen" is a widely used over-the-counter analgesic (pain reliever) and antipyretic (fever reducer). It is also known as paracetamol, or APAP. It is typically used for mild to moderate pain relief, such as relief of headaches. It is a major ingredient in numerous cold and flu remedies. In combination with opioid analgesics, paracetamol can also be used in the management of more severe pain such as post surgical pain and providing palliative care in advanced cancer patients. Acute overdoses of paracetamol can cause potentially fatal liver damage and, in rare individuals, a normal dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including under the brand name Tylenol®.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under various brand names including, Intensol®, Xanax®, and Xanax XR®. It is a schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and Professions code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amitriptyline" is a drug primarily used to treat a number of mental illnesses, including major depressive disorder and anxiety disorders, and less commonly attention deficit hyperactivity disorder (ADHD) and bipolar disorder. Other uses include prevention of migraines and the treatment of neuropathic pain. It belongs to a group referred to as tricyclic antidepressants, and a believed to increase levels of a chemical called serotonin in the brain. It is sold under the brand name, Elavil®, among others. It is a dangerous drug as defined in Business and Professions code section 4022.

"Amoxicillin" is a penicillin antibiotic medication used to treat infections and stomach ulcers. It is sold under the brand name Moxatag®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Belsomra®" is a brand name for suvorexant, which is a medicine that is used to treat insomnia. Suvorexant is in a class of medications called orexin receptor antagonists. It works by blocking the action of a certain natural substance in the brain

that causes wakefulness. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Commonly prescribed benzodiazepines include alprazolam (Xanax®), lorazepam (Ativan®), clonazepam (Klonopin®), diazepam (Valium®), and temazepam (Restoril®), Risks associated with use of benzodiazepines include 1) tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving. Before initiating a course of treatment, patients should be explicitly advised of the goal and duration of benzodiazepine use. Risks and side effects, including risk of dependence and respiratory depression, should be discussed with patients. Alternative treatment options should be discussed. Treatment providers should coordinate care to avoid multiple prescriptions for this class of drugs. Low doses and short durations should be utilized.

"Clonazepam" is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is also sold under the brand name Klonopin®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

"Depakote®" is a brand name for sodium valproate or divalproex sodium which is an anticonvulsant mood stabilizer drug that can be used to treat bipolar disorder and seizures. It can also help prevent migraine headaches. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Diazepam" is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It can produce psychological and physical dependence and should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. It is sold under the brand name Valium®. It is a schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug as designated in Health and Safety Code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold under the brand name Neurontin® among others. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more active than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®,

Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Including" or "included" means, "including, without limitation."

"Ingrezza®" is a brand name for valbenazine which is a medication used to treat involuntary movements of tardive dyskinesia. It acts as a vesicular monoamine transporter. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Lisinopril" is a medication used to treat high blood pressure and heart failure. It can also reduce the risk of death after a heart attack. It belongs to a class of drugs known as angiotensin-converting enzyme (ACE) inhibitors, which are heart medications that widen, or dilate, blood vessels to increase the amount of blood pumped by the heart and lower blood pressure. They work by causing relaxation of blood vessels as well as a decrease in blood volume, which leads to lower blood pressure and decreased oxygen demand from the heart. It is sold under the brand name Qbrelis®, Zestril®, and Prinivil®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Lorazepam," is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is sold under the brand name Ativan® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Lurasidone" is an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is sold under the brand name Latuda® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Maxalt®" is a brand name for rizatriptan, a medication used to treat migraine headaches. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Mirtazapine" is an antidepressant primarily used to treat depression. It is often used to treat depression complicated by anxiety or trouble sleeping. It is sold under the brand name Remeron® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Naltrexone" is a medication primarily used to manage alcohol dependence and opioid dependence. It is sold under the brand names, ReVia® and Vivitrol®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Norco®" is a brand name for acetaminophen and hydrocodone. This combination of hydrocodone and acetaminophen is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerate. Other brand names for this combination of drugs include Hycet®, Lorcet®, Lortab®, Maxidone®, Vicodin®, Zamicet® and Zydone®.

"Olanzapine," sold under the brand names Zyprexa Relprevv®, Zyprexa Zydis®, and Zyprexa® and Losec®, is a medication used in the treatment of mental

disorders, including schizophrenia and bipolar disorder. It is a dangerous drug as defined in Business and Professions code section 4022.

"Oxazepam" is a short-to-intermediate-acting benzodiazepine. It is used to treat anxiety and insomnia and in the control of symptoms of alcohol withdrawal syndrome. It is sold under the brand name Serax®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(23), and a dangerous drug as defined in Business and Professions Code section 4022.

"Percocet®" is a form of "oxycodone," which is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand name, including OxyContin® (a time-release formula) and Roxicodone®. Oxycodone is also available in combination with other drugs and sold under brand names including, acetaminophen (Endocet®, Percocet®, Roxicet®, and Tylox® among others); aspirin (Endodan®, Percodan® and Roxiprin® among others); and ibuprofen (Combunox®). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

"Propranolol" is a medication used to treat high blood pressure, chest pain (angina), and uneven heartbeat (atrial fibrillation). It can also treat tremors and proliferating infantile hemangioma. In addition, it can also be used to prevent migraine headaches. It belongs to a class of drugs known as beta blockers (which are medications that reduce your blood pressure and work by blocking the effects of the hormone epinephrine, also known as adrenaline; beta blockers cause the heart to beat more slowly and with less force, which lowers blood pressure). It is sold under the brand names Inderal LA®, Hemangeol® and InnoPran XL®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Prozac®" is a brand name for fluoxetine, a medication used to treat depression, obsessive-compulsive disorder (OCD), bulimia nervosa, and panic disorder. It belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It is dangerous drug as defined in Business and Professions code section 4022.

"Quetiapine" is an atypical antipsychotic drug used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. It is sold under the brand name Seroquel®, among others. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Risperidone" is an antipsychotic medication. It is generally used to treat schizophrenia, bipolar disorder, and irritability in people with autism. It is sold under the brand name "Risperdal®." It is a dangerous drug pursuant to Business and Professions code section 4022.

"Rozerem®" is a brand name for ramelteon, a sedative medication used to treat insomnia. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Soma®" is a brand name for carisoprodol. It is a muscle-relaxant and sedative. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code

section 4022.

"Sonata®" is a brand name for zaleplon, a sedative medication used to insomnia. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"TD" means tardive dyskinesia, which is a condition affecting the nervous system and causes repetitive, involuntary movements, such as grimacing and eye blinking. It is often caused by long-term use of some psychiatric drug, which are used to treat psychiatric conditions.

"Tegretol®" is a brand name for carbamazepine, which is an anticonvulsant medication used to treat seizure, nerve pain and bipolar disorder. It is dangerous drug as defined in Business and Professions code section 4022.

"Temazepam" is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is sold under the brand names Restoril® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Business and Professions Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. Tramadol is sold under various brand names, including Ultram® and ConZip®. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Trileptal®" is a brand name for oxcarbazepine, an anticonvulsant medication used to treat epileptic seizures. It is dangerous drug as defined in Business and Professions code section 4022.

"Venlafaxine" is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression. Venlafaxine is used to treat major depressive disorder, anxiety and panic disorder. It is sold under various brand names, including, Effexor XR®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Zolpidem" is a sedative drug primarily used for the treatment of trouble sleeping. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand name Ambien®. It is a schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Business and Professions Code section 4022.

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FACTUAL ALLEGATIONS

Patient A.[1]

10. The Board received a complaint from Patient A, a former patient of Respondent alleging that he had been her doctor for 18 years and that she initially saw him for domestic violence counseling. She alleged that Respondent prescribed at least 17 different medications to her during that time, not including the six medications that she was currently prescribed. She further alleged that Respondent failed to adequately monitor her heart health despite a family history of heart disease and diabetes. Most recently, Respondent failed to refill Patient A's medications due to a balance she owed to Respondent's office. She further alleged that Respondent had been prescribing Norco® and diazepam to her for over ten years, and that when she confronted him with patient abandonment, he only refilled the Norco® prescription for her. She stated that no doctor should "blithely" prescribe to a patient such as her for years.

11. On or about November 12, 2020 and January 29, 2021, an investigator and medical consultant interviewed Respondent ("First Interview" and "Second Interview," respectively) on behalf of the Board regarding Patient A and Patient B. At the First Interview, Respondent admitted that his prescribing to Patient A was not within the standard of care for each of diazepam (Valium®) and Norco®.

12. Respondent had treated Patient A, a woman, for 18 years until February 2018 when she was 57 years old. However, due to issues, including possibly a flood and staffing changes, his medical records for Patient A are only available beginning from 2014. Respondent diagnosed Patient A with Axis I, post-traumatic stress disorder (PTSD) and Axis III, migraine headaches (her primary complaint to Respondent). PTSD and migraine headaches are co-morbidities. According to Respondent, Patient A, a Canadian citizen, did not have medical insurance and paid for her visits in cash. She was a paralegal by profession.

13. A CURES report for the period from on or about June 29, 2011 through on or about June 29, 2018 revealed that Respondent wrote regular (approximately monthly) on-going

[1] Letters are used in lieu of names to address privacy concerns.

prescriptions to Patient A for controlled substances, including, hydrocodone with acetaminophen (7.5-325),[2] Vicodin ES® (7.5-750) and diazepam.[3] However, many prescriptions do not have a corresponding documented in-person patient visit with Respondent. During 2016 and 2017, Patient A filled prescriptions from Respondent at least 13 times each year including 780 pills per year of diazepam. Similarly, in 2015, Patient A filled prescriptions by Respondent 13 times for 1,950 pills of Norco®. When confronted with these amounts at the First Interview, Respondent seemed surprised that the patient was filling so many pills. In addition, Respondent also regularly prescribed Maxalt® and propranolol to Patient A.

14. At the Second Interview, Respondent stated that Patient A suffered from post-traumatic stress and "has a major depression history in the past," and that he was constantly "reviewing those symptoms [to make] sure they don't come back." He also stated that she has a "migraine headache daily, 40 years, since age nine -- uh -- worse with periods until . . . 2014, when she got menopausal."

15. Respondent's medical records for Patient A included notes beginning in 2014 which document a history of extensive childhood trauma, involving physical, sexual and emotional abuse, as well as adult sexual abuse and include chart notes for the following dated patient encounters: May 27, 2014, July 20, 2015, April 12, 2016, June 8, 2017[4] and February 22, 2018. Each visit includes a diagnosis of PTSD and migraine headaches. The chart notes dated July 20,

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[2] Including the following dates: January 26, 2015, February 25, 2015, March 26, 2015, April 24, 2015, May 26, 2015, July 27, 2015, August 26, 2015, September 29, 2015, October 31, 2015, November 2, 2015, November 5, 2015, December 16, 2015, January 1, 2016, March 1, 2016, April 13, 2016, May 16, 2016, June 18, 2016, July 21, 2016, August 30, 2016, October 14, 2016, November 19, 2016, December 28, 2016, February 3, 2017, March 9, 2017, April 13, 2017, May 24, 2017, July 5, 2017, August 22, 2017, October 5, 2017, November 22, 2017, January 4, 2018 and February 25, 2018.

[3] Including the following dates: December 29, 2014, January 23, 2015, February 18, 2015, March 17, 2015, April 14, 2015, May 11, 2015, June 8, 2015, July 5, 2015, July 31, 2015, August 31, 2015, September 28, 2015, October 27, 2015, November 23, 2015, December 10, 2015, January 8, 2016, February 3, 2016, March 3, 2016, April 1, 2016, April 30, 2016, May 30, 2016, June 29, 2016, July 25, 2016, August 23, 2016, September 20,. 2016, October 18, 2016, November 16, 2016, December 15, 2016, January 12, 2017, February 10, 2017, March 8, 2017, April 5, 2017, May 2, 2017, May 29, 2016, July 5, 2017, August 3, 2017, August 30, 2016, October 1, 2017, October 31, 2016, November 27, 2017, December 27, 2017 and February 3, 2018.

[4] At this visit, Respondent documented her use of Norco® and diazepam, but wrote that she rarely took these drugs. He also wrote that she took a shot of Baileys® with her coffee.

2015, April 12, 2016, and June 8, 2017 also include a diagnosis of "MDD" (major depressive disorder).

16. Respondent's medical records for Patient A, beginning in 2014, also included prescriptions to Patient A for multiple medications, including Norco® and Maxalt®. Respondent also stated at his First Interview that he prescribed drugs to Patient A after she would call him, including on or about November 13, 2017. Respondent acknowledged that he considered these patient encounters as practicing telemedicine. He also acknowledged that he did not take temperatures of patients at patient visits and asked the patients to provide their blood pressure and heart rate.

17. In or around December 2017 or January 2018, Patient A called Respondent's office. The receptionist told her that Respondent's wife required that Patient A come into the office to make a payment, before she could pick up her prescription. According to Patient A, she periodically carried a balance with Respondent's office.

18. On or about February 21, 2018, Patient A wrote a letter to Respondent, expressing her shock and sadness when she was informed on or about February 15, 2018 that Respondent was requiring that she pay her outstanding balance with Respondent's office and come for an in-person appointment in order to obtain a prescription for Norco®. She accused him of lying about his wife and expressed concern about her risk for withdrawal symptoms without her medications.

19. On or about February 22, 2018 (the final patient encounter), Respondent saw Patient A. According to Respondent, he told her that their patient/physician relationship would be discontinued and believed that her migraine headaches were stable. However, the progress note does not contain any documentation about the termination of care. According to Respondent, she had an outstanding bill with him. The note also documents a prescription for Norco®, a statement that the patient "needs payment plan/agrees," and the name of Dr. A. At the Second Interview, Respondent identified Dr. A. as a new primary care physician that Patient A had "finally found." Instead of listing the other medications she was taking, this note states, "see list." Although Respondent stated at his First Interview that he believed her termination was fine because she no longer had psychiatric medical problems, his progress note for this visit

documents the following findings, which are similar to descriptions of her PTSD symptoms in other notes: "Associations: 'she can get tangential. With triggers, she can ... but she is able to reorganize herself;' Insight: 'she has a tendency to have difficulty with trauma triggers;' Other findings: 'Tendency to go into survival mode, as opposed to flourishing.'"

20. Respondent's records include a letter dated February 22, 2018 from Respondent to contact the County Medical Society for the names of primary physicians to treat her. The records also contain a blank "authorization for release of information." There is an undated handwritten note on the letter stated, "Rev'd." However, there is no documentation about how or when this letter was delivered to Patient A. The letter states that Patient A's "condition" with her headaches has been "interpreted as stable enough," and that utilizing a "comprehensive medical system is better." The letter does not discuss a psychiatric diagnosis, psychiatric treatment recommendations, or whether Respondent recommends that Patient A seek care with another psychiatrist.

21. A prescription request, dated March 4, 2018 from Super Rx pharmacy for diazepam, 5 mg # 60 is signed as not authorized by Respondent on March 8, 2018.

22. Respondent's records include a copy of his February 22, 2018 letter to the patient with the following phrase circled, "1-3 months," and the addition of a hand written note stating "Please refill the diazepam that Dr. G and I spoke about; the pharmacy informs me they have notified you twice already, thank you [Patient A]."

23. On or about March 19, 2018, Patient A wrote another letter to Respondent stating that she had not received the diazepam yet, and that on March 12, 2018, she had called the office (after the pharmacy had faxed twice and she had faxed three times) and been told that she had to come in person to Respondent's office to make a payment and pick-up the prescription. She said she would not do that because this was "gamesmanship," because Respondent had always called-in prescriptions for this medication. In this letter, she reported having missed work due to lack of sleep, and gone through "withdrawal" despite having reduced her dose of diazepam as of her last visit on February 22, 2018.

24. Respondent failed to adequately address the issues for Patient A with an abrupt

discontinuation of benzodiazepine medications after nearly two decades of continuous use, including that it would place the patient at risk of withdrawal with severe discomfort, and possible serious medical risks including seizures. Despite having treated the patient for nearly two decades (often prescribing controlled substances over the phone without an in-person evaluation), and his familiarity with her extensive trauma history (including regularly prescribing controlled substances to her), and having recorded her "boundary problems" and problems with transference early in their relationship (on or about May 27, 2014) and her continued struggles with "survival versus mastery" in his last clinical visit with her on or about February 22, 2018, he nevertheless failed to adequately appreciate that the manner of his termination of his treatment for her could result in the possibility of significant emotional trauma from the perceived unexpected and arbitrary abandonment associated with his "new office policy." He also failed to adequately inform her about why and how she could obtain psychiatric care and medication maintenance (especially in light of her long-term benzodiazepine use) in the future, including emergency psychiatric care, and/or document his discussion with and/or correspondence to the patient.

25. At his Second Interview, Respondent stated that Patient A would say "she didn't need any more psychiatric medical care" and that "she didn't have a psychiatric medical problem any longer." He also stated that she let him know that Patient A finally had a doctor [primary care doctor]. He stated that he was never her primary care doctor. However, Respondent also stated that Patient A "frequently falls into or slides into symptoms" – "survival mode." However, he also stated she took three or four of the Norco he gave her per migraine incident.

Patient B.

26. At his First Interview, Respondent stated that he first saw Patient B, a 63-year-old man, in or around February in 2004, and that Patient B was a retired school teacher from New York who came to see Respondent about his "treatment-resistant depression." Respondent also stated that Patient B "always had difficulty with anxiety and sleep at night."

27. Thereafter, Respondent continued to treat and prescribe drugs to Patient B, but failed to adequately document an assessment and/or rationale for the prescriptions, including lorazepam, alprazolam and zolpidem, among others. He also prescribed Belsomra® and Rozerem®, which

also cause sedation.

28. On or about April 5, 2016, Respondent received a letter from the pharmacy warning him of the danger of prescribing quetiapine[5] and risperidone.

29. On or about April 12, 2018, Respondent saw Patient B with a chief complaint documented as "wonder if meds cause problems" and about light headedness. Respondent also refilled Patient B's prescription for zalepion (Sonata®) as well.

30. On or about June 10, 2018 and May 4, 2019, Patient B filled a prescription for zalepion (Sonata®).

31. On or about April 16, 2019 and April 23, 2019, Respondent reported that Patient B had been taking lorazepam, 4 mg per day and zolpidem, 40 mg per day, in addition to Belsomra® and Ingrezza®.

32. On or about October 31, 2019, Respondent documented that Patient B was feeling lightheaded, dizzy, pressure, and a "heavy head, neurologically speaking."

33. Respondent wrote a prescription to Patient B dated November 14, 2019, for Ambien®, 10 mg, one or two per night (120 pills), and for alprazolam (Xanax®), 1 mg, two per day (180 pills). These drugs are contraindicated for Patient B, due to issues such as dizziness, balance, sedation and coordination.

34. In a questionnaire dated December 3, 2019, Patient B listed his top three concerns as dizziness, balance, and light headedness. Respondent's records also include several warning letters from the pharmacy indicating the risks of the medications Respondent was prescribing to Patient B.

35. On or about December 5, 2019, Respondent referred Patient B to a cardiologist in connection with complaints of dizziness and orthostatic hypertension. At this patient encounter, Respondent prescribed the following drugs to Patient B: amitriptyline,[6] Ingrezza®, Xanax® and Ambien® (up to two 10 mgs a day). Each one of these drugs can cause dizziness. At his First Interview, Respondent stated that Patient B always took 10 mg of Ambien® that he prescribed to

[5] Common side effects include dizziness, drowsiness and tiredness.
[6] Common side effects include drowsiness, weakness or tiredness.

this patient.

36. On or about January 20, 2020, Respondent reported that Patient B's prescriptions included amitriptyline, Ingrezza®, Xanax®, Ambien®, and Ativan®, and that his "best formula" for Ambien® was "12.5 times two at bedtime"[7] and "'Xanax' was one Ativan 1 mg at night."

37. On or about January 30, 2020, Patient B filled a prescription for lorazepam at 1 mg, 90 pills from Respondent, despite the patient's prescriptions for Ambien® and alprazolam on or about November 14, 2019 and for amitriptyline on or about January 20, 2020.

38. On or about March 16, 2020, Respondent had a patient encounter with Patient B and his wife spoke to Respondent about taking two amitriptyline per day. She wanted to know if Respondent could lower his dose; he was dizzy.

39. On or about June 11, 2020, Respondent saw Patient B who was a 79-year-old man at the time with complaints about balance, light-headedness and falling and hurting his knee. He had his knee replaced in January and while he had previously used a walker, he did not want to use a walker again. His wife played tennis at the time. He also had a history of seeing a physical therapist in 2019.

Patient C.

40. During the period from in or around July 2015 until in or around April 2018, Respondent treated Patient C, a male aged 60 (in July 2015) with a principal diagnosis of alcoholism. During that time, Respondent's medical practice was located in Palm Desert, California and Patient C lived in Arizona (from in or around July 2015 until August 2016) and Montana (from in or around October 2016 through in or around April 2018). During his care for the patient, Respondent diagnosed Patient C with a primary diagnosis of alcoholism, in addition to PTSD, MDD, ADD (Attention Deficit Disorder), bipolar disorder and Dementia. He prescribed a combination, naltrexone and acamprosate (FDA approved), as well as several non-FDA approved medications, to Patient C. However, he failed to adequately document his rationale for these medication choices, and failed to adequately monitor Patient C for their

[7] Presumably, this was for 12.5 mg of Ambien CR® and the recommended dose is 12.5 mg maximum.

efficacy and side-effects.

41. This matter arose upon the Board's receipt of a complaint expressing concern about Respondent's excessive prescribing of lorazepam, quetiapine and divalproex to Patient C while he was continuing to consume alcohol, and without seeing Patient C in-person for patient encounters. In or around April 2018, Respondent's care for Patient C ended when he terminated care and referred him to another doctor and an addiction treatment counselor in Montana where the patient was living. In response to the complaint, Respondent alleged that he repeatedly attempted to transfer care for Patient C to a local physician during the time he provided medical care for him, but that he was unsuccessful and therefore continued to treat him. However, Respondent's medical records for Patient C fail to include adequate documentation of such alleged repeated attempts to transfer his medical care to a local provider in either Arizona or Montana until in or around March 2018. In addition, while documentation dated in 2017 indicates that the patient was going to see a primary physician in Montana and addiction counseling at an addiction treatment center in Montana, Respondent failed to adequately attempt to transfer his care of the patient to a local provider, or explain to the patient that he could not continue to treat him without periodic in-person examinations, and that he could not prescribe in another state, and/or he failed to adequately document the same.

42. In or about November 12, 2020, an investigator and medical consultant interviewed Respondent on behalf of the Board about Patient C ("Third Interview"). At the Third Interview, Respondent stated that he only had a California medical license, and did not have a license to practice medicine in any other state.

43. Respondent committed unprofessional conduct (including gross negligence, negligence and incompetence) for years with respect to his care of Patient C, a seriously ill patient, by treating him without periodic in-person examinations and by remotely prescribing medications to him in another state without a license to practice medicine in the state where the prescriptions were filled. He continued to do this despite the fact that he should have known that patients with significant alcohol/substance use disorders are often not adherent to treatment, not reliable about their substance use patterns, and otherwise tend to hide or minimize problems

associated with their substance misuse.

44. Patient C also suffered from repeated serious complications from his continued excessive alcohol consumption during the period of treatment by Respondent for that condition. Severe alcoholism is an extremely serious, often lethal condition and Respondent failed to adequately adjust his treatment plan despite evidence that it was not working.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

45. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of three patients. The circumstances are as follows:

Patient A.

46. On or about May 27, 2014 and thereafter, Respondent committed the following acts, individually and/or collectively, of gross negligence, in connection with his treatment and care of Patient A, as follows:

(A) Respondent excessively prescribed medications, including controlled substances to Patient A, including benzodiazepines and opioids. Respondent failed to adequately assess, re-assess and/or monitor his continuous prescribing of controlled substances to Patient A. He failed to adequately monitor her use of controlled substances, including through the use of biological toxicology testing. He also failed to adequately obtain and/or document an informed consent from the patient, including adequate documentation of his explaining all of the attendant risks, benefits and alternatives. He failed to adequately consider and investigate whether Patient A was actually "rarely" using opioids and benzodiazepines, i.e., 3 to 4 Norco® per migraine episode. He failed to adequately assess her in person before continuing her medications. He failed to recognize and/or address that opioids and diazepam could have dangerous synergistic effects when combined, this was even in light of her reporting to him her past history of alcohol use and that she used Baileys® in coffee throughout the day.

(B) Respondent inappropriately prescribed benzodiazepines to Patient A. His psychiatric diagnoses for her were PTSD and MDD. He maintained Patient A on

benzodiazepines for years at high doses to treat PTSD[8] and insomnia. He failed to adequately obtain and/or document her informed consent to these treatments which were unorthodox. He failed to adequately inform her about the benefits, risks (including of abuse, dependence tolerance and withdrawal, sedation, and cognitive impairment) and alternatives to treatment. Further, diazepam is a benzodiazepine with long-acting metabolites and inappropriate to address sleep issues, i.e., a build-up of long acting metabolites can occur and exacerbate with age. Short term use of short-acting agents is more appropriate for sleep issues. Prescribing of long-acting benzodiazepines also required consistent follow up and re-assessment for effectiveness (including through intermittent use) and monitoring of side effects, which Respondent failed to do for Patient A. He failed to adequately perform and/or document any systemic monitoring of Patient A's sleep function, attempt at behavioral treatment, and/or discussion of alternatives (including trials of CBT which may have had more efficacy) to diazepam. His documentation was also inconsistent, e.g., indicating 5 mg twice a day and 10 mg qHS.

(C) Respondent inappropriately prescribed opioids to Patient A, including on a long-term basis. Opioids are not recommended as a first-line treatment for migraines, and are associated with avoidable risks, including risks for abuse, tolerance and dependence. He also failed to appropriately treat her migraines. Respondent failed to adequately assess, re-assess, monitor and/or document details about Patient A's migraines systematically and the efficacy or adverse effect from his treatment, e.g., the frequency, duration and severity (impact on functionality) of migraines. He also failed to adequately recognize and/or consider that excessive opioid treatment could actually increase the risk of headaches and chronic migraines. He failed to adequately explain why he used opioids to treat Patient A medically and/or obtain her informed consent after explaining all of the risks, benefits and treatment alternatives. He failed to adequately medically treat Patient A, including by inappropriately prescribing Maxalt®.

(D) Respondent's medical record keeping for his treatment of Patient A represents gross negligence. Respondent also committed gross negligence by failing to adequately assess and/or examine the patient (including by obtaining an adequate history and symptomology from

[8] Which is not recommended to treat this condition.

the patient), and/or by failing to adequately document the same. At the Second Interview, Respondent was asked to read his records due to their illegibility. The illegibility of Respondent's records would have made it extremely difficult for another healthcare provider to review them. This is further complicated by his underuse of standard medical terminology in his description of findings. In addition, the organization of Respondent's progress notes did not follow standard divisions of the medical assessment, despite the template for his notes. For example:

(i) Respondent failed to adequately document Patient A's symptoms of her main complaints, e.g., headache frequency, PTSD symptoms, and/or track the course of her condition(s) over time and her responses to treatment.

(ii) Respondent's progress note dated May 27, 2014, failed to include an adequate description of the patient's current PTSD Symptoms. His record for the visit failed to include a diagnostic assessment (i.e., a Diagnostic and Statistical Manual of Mental Disorders, "DSM" criteria for PTSD) for Patient A, who had a history of trauma. Respondent failed to adequately assess Patient A for such typical symptoms as nightmares, flashbacks, avoidance, physiological hyperarousal upon exposure to reminders, sleep disturbance, hypervigilance, startle reactions, and altered cognitive (self-blame, other self-concept issues) or dissociative symptoms in connection with his diagnosis of PTSD, and in monitoring the condition. Respondent also failed to adequately address Patient's A's symptoms and responses to treatment, including to medications, and how any co-morbidities such as depression would be affected. Such information would affect treatment plans and possible medications, including fluoxetine, paroxetine, sertraline or venlafaxine, among which only paroxetine and sertraline are indicated for PTSD. He failed to adequately document whether he considered Patient A's undated list of medications which she used prior to age 37/38 (1994 or 1995).

(iii) Respondent's progress note dated May 27, 2014 also failed to include documentation of an assessment / history of drug use other than her denial of use of an illicit substance or medical marijuana on or about April 12, 2016, and her consumption of Baileys® in coffee throughout the day.

(iv) Respondent failed to adequately document Patient A's history of suicidal thoughts/behavior, which is common in victims of extensive childhood trauma such as Patient A.

(v) Respondent's records included a diagnosis of MDD on or about April 12, 2016 and June 8, 2017. However, his records failed to adequately document any history of depressive symptoms, episodes, or treatment for this condition.

(vi) At his Second Interview, Respondent explained in regards to Patient A's visit on or about April 12, 2016, that "she does have a much more disciplined way in her affect recognition management and skills strategies. . . . stronger "ARMS" . . . a much more diagnostic and therapeutic way of saying things . . . a disorder has been replaced with the word diagnosis . . . you want diagnosis, and you don't want disorders." This way of describing PTSD differs from the standard nomenclature (e.g., DSM). Further, "stronger" ARMS seems to be a subjective global judgement. How will it be determined when her ARMS is strong enough, or when additional treatment is required?

(vii) At his Second Interview, Respondent explained in regards to Patient A's visit on or about June 8, 2017, that she is not the person she stated and described big "mind F experience," and F is a letter to represent one word . . . and used the acronym "AMAP" which meant as much as possible. He also described her physical health and five goals (home, school, work, play, jobs and self) and that there were the "third of the two rules, of basically the diagnostic and therapeutic is to do the kindness, the Hippocratic. The double H test. Helping, not hurting self and others." Another health care provider would have difficulty interpreting Respondent's documentation of this visit.

(viii) At his First Interview, Respondent, in regards to Patient A's visit on or about February 22, 2018, deciphered his documentation which listed information in a very unsystematic way and failed to include specific symptoms of PTSD (or MDD), the psychiatric medical condition(s) he treated.

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Patient B.

47. In or around April, 2014, and thereafter, Respondent committed the following acts, individually and/or collectively, of gross negligence, in connection with his treatment and care of Patient B as follows:

(A) Respondent inappropriately prescribed medications to Patient B, including controlled substances such as benzodiazepines, zolpidem and Belsonra®. Respondent excessively prescribed controlled substances, and failed to adequately endeavor to prescribe medications at the lowest effective dose and for short durations. He failed to adequately treat Patient B's sleep difficulty. Benzodiazepines are a high risk medication for elderly patients due to their sedative effects. There is a heightened risk of falls and concomitant risk of hip fracture in elderly patients who are prescribed benzodiazepines. In addition, zolpidem should be prescribed at a low dose; 5 mg is the recommended dose for an elderly patient. Further, concurrently prescribing these medications is especially dangerous in elderly patients. Although Respondent noted the risk of falling, he failed to adequately assess, re-assess, and/or document his rationale for his medication treatment for Patient B. He failed to adequately recognize that the drugs he provided to the patient, including amitriptyline, Ingrezza®, Xanax® and Ambien® could have caused dizziness. He failed to adequately provide informed consent for the treatment he provided to him as well, including by explaining the risks, benefits, and treatment alternative (such as CBT) for the patient, especially in light of the high doses of sedative drugs he prescribed to Patient B.[9] Several warning letters from the pharmacy are in Respondent's records about the possible adverse effects from the drugs Respondent prescribed to Patient B, including quetiapine and amitriptyline. He also failed to adequately recognize the dangerous side effects that could result when he prescribed the dangerous drugs to the patient in high doses, including 10 mg of Ambien® and 1 mg of Ativan® on an on-going basis, including balance, coordination and cognition. Respondent also failed to adequately adjust his treatment of Patient B in light of these dangers.[10]

(B) In or around April 2014 and thereafter, Respondent failed to adequately evaluate, re-

[9] Such high doses could be considered "off-label" use.

[10] This was despite concerns raised by the patient's wife about these very risks, i.e., dizziness/unsteadiness and loss of balance.

evaluate and/or monitor his continuous prescribing of controlled substances to Patient B, including for any adverse effects from the drugs he was prescribing. Respondent also failed to adequately obtain and/or document an informed consent from Patient B for each of the dangerous drugs he prescribed to him, after explaining all of the attendant risks, benefits and alternatives to the medications he prescribed to Patient B.

(i) A pharmacy sent Respondent a letter dated May 15, 2017 regarding a prescription for amitriptyline and stated that a prior authorization ("PA") was required. In another letter dated December 20, 2017, the pharmacy warned Respondent about the dangers of "high risk medication," viz., tricyclic antidepressant in older adults and the increased risk of adverse side effects related to its anticholinergic properties, including impaired coordination, memory dysfunction and cognitive impairment in the elderly.

(ii) Respondent's records fail to adequately document that he informed the patient about the dangers of using the medications he prescribed, including quetiapine and olanzapine, with the attendant risks for weight gain, type II diabetes mellitus and hyperlipidemia. In addition, both amitriptyline and quetiapine are associated with risk of QTc prolongation and associated cardiac arrhythmia, and their use requires monitoring of cardiac health. Respondent failed to adequately perform and/or document an informed consent with the patient, including by explaining the benefits, risks, and alternatives to treatment.[11] In addition, Ingrezza® and amitriptyline use could increase nortriptyline levels and pose a risk for cardiac toxicity. Respondent failed to obtain any relevant testing, such as an electrocardiogram or blood tests showing level of amitriptyline or nortriptyline blood levels. Ingrezza® could also induce somnolence and Parkinson-like symptoms and Respondent failed to adequately document that he informed the patient about these risks.

[11] There is a documented visit on or about March 16, 2020 when the patient's wife asked to decrease the amitriptyline from two to one per day and Respondent engaged in a discussion about the risks /benefits and lowered the dose. Similarly, a chart note dated February 26, 2020 does state, "safety, risk, benefit conversation" in a record that lists quetiapine, amitriptyline, zolpidem, Ativan®, Xanax® and Ingrezza®. However, the same note discussed a recent emergency room visit for a hypotensive episode with blood pressure of 50/42. An overdose from benzodiazepine and non-benzodiazepine sedative-hypnotics can cause hypotension, and there is no adequate documentation that Respondent informed the patient about these risks.

(iii) Respondent diagnosed and treated Patient B for TD. He failed to adequately consider that lurasidone[12] and olanzapine may cause symptoms associated with the condition. He also failed to adequately monitor the patient's progress over time (e.g., abnormal involuntary movement scale or "AIMS") and response to treatment, i.e., medications.[13] He failed to adequately inform the patient that quetiapine could cause or exacerbate TD.

(C) In or around April 2014 and thereafter, Respondent's medical record keeping of his treatment of Patient B represents gross negligence. Respondent also failed to adequately assess and/or examine the patient (including by obtaining an adequate history and symptomology from the patient), and/or document the same. At the Second Interview, Respondent was asked to read his records due to their illegibility. The illegibility of Respondent's records would have made it extremely difficult for another healthcare provider to review them. This is further complicated by underuse of standard medical terminology in his description of findings. In addition, the organization of Respondent's progress notes did not follow standard divisions for medical assessments, despite the template for his notes. For example:

(i) Respondent used a series of single words, some corresponding to current symptoms, past history, psychosocial history and medical terminology.

(ii) Respondent failed to adequately document Patient B's symptoms for his diagnoses. He failed to adequately assess and/or document Patient B's PTSD symptoms and progression from age five to 75. He failed to adequately document the longitudinal pattern of Patient B's sleep changes (e.g., whether chronic insomnia related to the mood disorder or PTSD). Further, it is unclear from his documentation whether Respondent's diagnosis of major depression was related to Patient B's sleep issues or other problems, i.e., whether there were changes in appetite, interests, energy level, self-worth, psychomotor activity level or suicidal thinking, in patterns corresponding to diagnostic criteria for a major depressive episode. He also failed to adequately assess and/or document Patient B's bipolar disorder.

(iii) Respondent's documentation of his patient encounters over time is

[12] Which he prescribed to the patient on or about November 13, 2018.

[13] Although he did estimate the AIMS score intermittently such as on or about May 15, 2017, April 12, 2018 and October 3, 2019.

difficult to follow and inconsistent. For example, Respondent's progress note dated March 3, 2020, stated the patient tried to cut the treatment with Xanax®. But later in the same note, he wrote, "Xanax sleeping good." In a questionnaire dated March 3, 2020, Respondent wrote that the patient only takes Ativan and not Xanax any longer. And, in a note dated March 16, 2020, Respondent wrote, "good follow up, compliance." However, this contrasts with the First Interview, when Respondent stated that the patient would often change his medications. Similarly, regarding the patient's TD issue, from on or about February 19, 2019 through March 16, 2020, the patient continued to suffer from possible issues including shortness of breath and Respondent nevertheless failed to adequately assess, treat and/or document the patient's TD by noting the symptoms and changes over time. He failed to adequately consider that it could have been related to possible withdrawal TD when the patient was taken off olanzapine. Further, on or about February 19, 2020, Respondent documented that Ingrezza® 80 mg "couldn't take it," and on or about October 31, 2019, he documented that 40 mg was "best" and 80 mg made it "worse." Yet, he continued to prescribe that amount to the patient for several months.

(iv) Respondent used medical terminology in an unusual way. On or about June 11, 2020, Respondent saw Patient B and found that he had "constitutional issues – uh – he felt stressed," and "his eyes and ears and heart are all that . . ." In that same chart note, Respondent referred to using dialectical behavior therapy ("DBT") and cognitive behavior therapy ("CBT") without qualification. Furthermore, at his Second Interview, Respondent stated, "Would pay more attention, curiosity of how he thinks and feels, as opposed to reacting to it. Most people I know I work with, we talk about reflective -- always reflective, never reactive. And likes that, a lot." This appears to be a description of therapeutic components of mindfulness which is used as a component of CBT, while DBT was developed to assist young women with borderline personality disorders reduce their injurious/parasuicidal behavior. Thus, Respondent failed to adequately explain in his documentation how Patient B received both CBT and DBT. Additionally, at his Second Interview, Respondent stated that he used CBT, DBT and "PIOP" (psychodynamic insight oriented psychotherapy) which is a long-term treatment modality involving the therapist's facilitating the patient's understanding of the influence of unconscious

processes on emotions, thinking and behavior (based on principles usually attributed to Sigmund Freud). Thus, his use of this term is inadequately documented. Further, CBT, DBT and PIOP are not typically used simultaneously in a patient. Yet, Respondent stated at the Second Interview that; "If I say do not think of the color red, it's physically impossible . . . We kind of focus on positive confrontation . . . its ongoing growth and development . . . that goes with sleep hygiene, and "[H]is cognitive behavioral therapy, his dialectical behavioral therapy, where he can pay more attention just observing and be kind of fascinated and curious with it, and then deciding what it kind of means, the way he thinks, feels and says, and does; He likes that;" and "He had a history of crying a lot as a child – um – when he was in the hospital, in the iron lung, and all that other stuff he went through before, and the detail of that and how bad it was and what he did from then until now to make it better was very helpful for him that's the insight oriented and gives him chance to be more cognitively, emotionally, and behaviorally restructuring." In a discussion of the patient's TD, he stated at the Second Interview that he discussed "valbenazine and meclizine" and that he went through a detailed treatment review, helping the patient to integrate and be more diagnostic and therapeutic."

Patient C.

48. In or around April, 2014, and thereafter, Respondent committed the following acts, individually and/or collectively, of gross negligence, in connection with his treatment and care of Patient C as follows:

(A) In or around July 2015, and thereafter, Respondent committed gross negligence when he practiced medicine in a state where he did not have a valid and effective medical license. Respondent possessed a valid medical license only in California during the time he treated Patient C (who resided in other states), including by prescribing controlled substances to him. In addition to violating the law, Respondent failed to recognized that he would not be able to effectively handle psychiatric emergencies, arrange for emergency assessment and hospitalizations, and coordinate care from California, especially in light of his unfamiliarity with applicable standards of care and local laws. Once realizing that Patient C would remain in another state, he should have transferred care for the patient to a licensed physician in the other

state, where the other physician could conduct regular in-person examinations of the patient. Respondent had multiple opportunities to transfer his care for the patient to another local provider. Yet, he continued to treat the patient.

(i) In or around July 2016, when the patient resided in Arizona, he had reportedly been seeing a new doctor. However, Respondent failed to adequately follow up about this doctor with the patient, including about his specialty and/or whether he could take over care for the patient, including in respect of his medications.

(ii) On or about January 30, 2017, Respondent identified that Patient C had scheduled an appointment in one week with a new primary care physician in Big Fork, Montana. Respondent should have informed the patient that coordination of care was necessary, and asked for the patient's authorization to share records with and to communicate his medical history to the new primary care physician. He should have informed the patient that he was going to transfer his care and could not continue to treat Patient C out of state. However, Respondent failed to attempt to coordinate care for Patient C. At the time of this visit, Patient C was consuming 15 alcoholic beverages per day.

(iii) On or about May 26, 2017, Respondent failed to follow-up with Patient C and/or document about whether the patient had seen the primary care doctor in Montana, or what she recommended.

(iv) On or about June 25, 2017, Respondent noted that Patient C was doing well, and tapering off of the medications Respondent had prescribed to him. However, he failed to follow up and/or document about the patient's prior scheduled local primary care doctor visit, and failed to transfer his care and end his remote treatment of the patient.

(B) In or around July 2015, and thereafter, Respondent committed gross negligence when he continued to treat Patient C without in-person examinations, including to perform adequate mental status examinations. At his Third Interview, Respondent stated that he continued to treat Patient C via telephonic conference calls. However, his documentation for his patient encounters fails to indicate that his visits were via telephone.

(C) In or around July 2015, and thereafter, Respondent committed gross negligence

when he inappropriately prescribed medications to Patient C, including benzodiazepines. Respondent excessively prescribed benzodiazepines for years on a monthly basis to Patient C who had alcohol use disorder and documented harm and evidence of misuse. Benzodiazepines should be prescribed in low doses for the shortest time possible in patients with alcohol use disorder because of the risks of tolerance, dependence and additive CNS depression when combined with alcohol. A patient's denial of misuse is not a reliable method of assessing the patient's potential harm. Respondent continued to prescribe large quantities of 2 mg lorazepam to Patient C, who had alcohol use disorder and suffered from (i) harmful drinking behavior, including DUIs, medical problems such as "brain damage," hepatitis and hip fracture, and (ii) misuse and overdose from lorazepam as discussed at the Third Interview (when he first learned about the patient's anxiolytic use disorder diagnosis and discharge summary from a treatment program in Florida).[14]

(i) On or about February 19, 2016, Patient C was admitted to a hospital for benzodiazepine intoxication.

(ii) On or about October 3, 2016, Respondent documented his first patient encounter after Patient C moved to Montana. He also prescribed both lorazepam and oxazepam to the patient, when the patient informed him he had difficulty with opioid withdrawal.

(iii) On or about January 10, 2017, Respondent prescribed a high dose of lorazepam (2 milligrams twice a day).

(iv) On or about January 30, 2017, Patient C reported to Respondent that he had suffered an alcohol related driving under the influence (DUI) incident two weeks earlier. However, Respondent failed to investigate whether his lorazepam prescription contributed to the DUI. He also failed to warn the patient that he would recommend suspending those prescriptions for safety. The patient also reported to Respondent that he was binge drinking 15 vodkas a day.

(v) On or about February 20, 2017, Patient C was transported to a hospital with an altered medical status. He had possibly overdosed on benzodiazepines and paramedics noticed that he was missing a substantial quantity of his Ativan®, prescribed from this doctor in

[14] Respondent continued to prescribe lorazepam to Patient C on or about March 14, 2018.

Palm Desert.

(vi) On or about May 26, 2017, Respondent prescribed lorazepam (2 mg BID as directed, 60 tablets with one refill) to Patient C. This was despite the patient having told Respondent that he was drinking 15 alcoholic beverages per day at the last documented patient encounter in January. Respondent failed to document any assessment of the patient or the medication's effects or safety. The patient also reportedly completed a rehab program and was taken off of the lorazepam in that program (Watershed).

(vii) On or about September 28, 2017, Patient C "confessed" to Respondent that he had "violated the script" and was taking five lorazepam pills per day instead of three. He wrote, "not toxic until" exceeds 8 mg. Patient C's friend was invited to participate in the meeting and stated that the patient functions "funky" when he has "too many benzo." In his plan, Respondent increased the patient's dose to lorazepam, 2 mg four times a day (#90). He also included a statement "Lorazepam 2 mg if he takes more, good to go" and "4 DUIs, caught and prosecuted." However, Respondent failed to counsel the patient about the danger of taking these large doses of lorazepam, nor about the inadvisability of taking more than prescribed, nor about the risks of using this medication in conjunction with alcohol, nor about the risk of benzodiazepine use contributing to hazardous driving.

(viii) On or about November 15, 2017, Respondent wrote in a progress note that the patient, while undergoing court mandated alcohol counseling, was taking "no benzos," and "Sometimes I get mad to myself if I take too many pills." He then prescribed lorazepam, 2 mg, bid, 30 pills to the patient.

(ix) On or about December 6, 2017, Respondent documented that the patient reported having a DUI problem and that his hands were shaking. The patient also stated that he gets "completely confused regarding medications." Respondent also prescribed lorazepam, 2 mg, tid, 90 pills to the patient, without instructions or an attempt to coordinate care.

(x) On or about March 13, 2018, a pharmacist informed Respondent that the patient came to the pharmacy on or about March 12 intoxicated and wanted more lorazepam. However, the pharmacist only provided "2 pills" (of lorazepam) because the patient had already

received 30 pills on March 7, 2018.

(xi) On or about March 14, 2018, Respondent prescribed lorazepam (2 mg TID, 90 pills) to Patient C. This was despite the patient reporting that he was in five days of "pure hell" and felt like "dying," and his employee was going to get him alcohol. Respondent placed the patient at risk of serious harm by prescribing a month's supply of a large dose (6 mg per day) of a sedative-hypnotic drug when he knew the patient had relapsed. There was no documentation in the note of his rationale for this decision. When asked about this at his Third Interview, Respondent acknowledged that this was not a safe prescription and that the patient should be in a hospital. On or about April 3, 2018, Respondent prescribed 90 pills of lorazepam with refills to the patient.

(D) In or around July 2015, and thereafter, Respondent committed gross negligence when he prescribed benzodiazepines to Patient C without medical indication. Benzodiazepines are not recommended for the treatment of alcoholism because of the risk of harm, including dependence, tolerance, abuse and withdrawal, except in limited situations such as acute alcohol withdrawal or where co-occurring disorders may indicate use in light of the other circumstances.[15] However, Respondent's records for this patient do not include any symptomatic or diagnostic basis for his continuous treatment of benzodiazepines for Patient C. Repeating a month's supply of benzodiazepines over a multi-year period is not standard treatment for alcohol withdrawal or sleep issues. Moreover, use of benzodiazepines in the setting of alcohol intoxication entails risks of harmful effects, including additive sedation, respiratory depression, and even death. Respondent failed to adequately assess, re-assess, and monitor Patient C for any benefits and harms or misuse, despite repeated instances where the withdrawal strategy clearly failed, and instances of misuse or overuse occurred.

(E) In or around July 2015, and thereafter, Respondent committed gross negligence and incompetence when he prescribed many dangerous drugs to Patient C without indication. Respondent prescribed medications to Patient C for years, including for citalopram (CelexaR®)

[15] When used to treat a co-morbid anxiety disorder, it should only be used after psychotherapy or antidepressants have failed, and then, only in limited quantities and at the lowest possible dose.

40 mg/day, divalproex (Depakote ERR®) 500 mg BID and quetiapine (SeroquelR®) 150-300 mg/d and other doses as needed for "severe agitation," without adequate documentation of any diagnostic indication(s) for these medications. Alcohol use disorder was not an indication for use of these medications during the treatment periods in question. In addition, use of acamprosate, naltrexone and the combination of these two is not indicated for alcohol use disorder. Furthermore, while gabapentin and topiramate may have some efficacy for individuals trying to achieve abstinence or reduce drinking severity, the abuse potential for gabapentin requires attentive monitoring. Antidepressants have minimal benefits, no benefit or even worsening of alcohol use outcomes when prescribed for this indication. In addition, use of antidepressants in patients with differential diagnoses of alcohol use related mood disturbance and independent co-morbidities must be carefully discerned and documented. Respondent treated Patient C for alcohol dependence, and intermittently for alcohol withdrawal. He failed to document an adequate rationale for Depakote® as well. Respondent also diagnosed Patient C with "MDD," "PTSD," and "ADHD." Quetiapine was not indicated for MDD. Neither citalopram nor quetiapine were indicated for the treatment of PTSD or ADD (assuming Respondent means attention deficit (hyperactivity) disorder). Respondent failed to adequately document any "off-label" rationale for use of his prescribing in those instances where Respondent presumably used citalopram, divalproex and quetiapine, nor any documentation that he informed Patient C that he used such medications in an "off-label" manner, or that he explained the risks, benefits, or alternatives to any of his medications. Finally, on or about September 28, 2017, Respondent prescribed lithium, 300 mg #60 with 3 refills, to Patient C, without a diagnosis of bipolar disorder, or without an explanation of the purpose, directions or potential risks and benefits, or without a recommendation for monitoring levels and other laboratory test results, including renal and thyroid functions and calcium metabolism. Respondent also prescribed lisinopril to the patient at this visit, but failed to adequately monitor the patient's lithium level which is important due to the risk of drug interactions.

(F) In or around July 2015, and thereafter, Respondent committed gross negligence when he failed to adequately monitor Patient C for potential adverse effects from the medications

he prescribed to him, and/or adequately obtain an informed consent from the patient regarding those prescriptions and/or document his interactions with the patient. Respondent failed to adequately consider and/or inform the patient about the potential adverse effects pertinent to medications he prescribed to Patient C.

(i) During his treatment of Patient C, Respondent prescribed citalopram (CelexaR®) 40 mg/day, divalproex (Depakote ERR®) 500 mg BID and quetiapine (SeroquelR®) 150-300 mg/day and other doses. However, Respondent failed to adequately monitor and/or document any monitoring for potential side-effects of these medications, including ECG monitoring for possible QTc prolongation (which increases the risk of serious cardiac arrhythmia[16]). Quetiapine is associated with risk of QTc prolongation, and Respondent prescribed this medication at substantial doses without documenting its indications, the monitoring for potential risks, or his having advised the patient of these risks.

(ii) Respondent prescribed quetiapine (indicated for schizophrenia and bipolar disorder and often used "off-label" for treating insomnia or other non-specific psychiatric symptoms such as "agitation") to the patient, but failed to adequately inform the patient about, and monitor periodically for, the risk of metabolic syndrome, including weight gain, hyperlipidemia, and type II diabetes.

(iii) Respondent also prescribed DepakoteR® (divalproex) for years to Patient C without documenting indications or adverse effects, including warning about, and monitoring for, serious risks of this medication such as pancreatitis, liver damage, hematotoxicity, including lowering of white blood cell counts or platelets, and hyperammonemic encephalopathy; nor monitoring the serum level of the medication (valproic acid level). Moreover, patients with chronic alcoholism are at risk of liver damage, and Respondent documented a diagnosis of hepatitis for Patient C. Yet, he failed to document any adequate concern about the possibility of valproate hepatotoxicity in a patient maintained on that medication who had hepatitis.

[16] The combination of two or more drugs with QTc prolongation potential increases the risk of serious arrhythmias.

(iv) On or about March 18, 2018, Patient C struggled with both alcohol and lorazepam overuse, and Respondent prescribed gabapentin to the patient to assist with withdrawal symptoms. However, his dosing was twice the manufacturer's maximum recommended daily dosage of 3,600 mg per day. He also documented findings of "ataxia and vertigo," which placed the patient at substantial risk of harm due to the high dosing. He failed to document any other possible alternatives to treatment for the patient, including referring the patient to the emergency room or collaboration in the care of the patient with the patient's local primary care physician.

(G) In or around July 2015, and thereafter, Respondent committed gross negligence when he failed to adjust/change his treatment plan in light of Patient C's deteriorating condition. Respondent maintained Patient C on a combination of naltrexone, acamprosate, divalproex, citalopram and gabapentin for years. However, divalproex, citalopram, quetiapine and gabapentin are not indicated to treat alcoholism. Further, Respondent failed to change his treatment regimen over time (e.g., replacing divalproex and/or gabapentin to topiramate, another anticonvulsant medication with better evidence for efficacy, as an adjunctive medication for helping patients achieve or maintain alcohol abstinence).

(i) Respondent also repeatedly prescribed gabapentin for preventing seizures during Patient C's tapering off of alcohol. However, Respondent failed to change this treatment even after the evidence indicated its inefficacy, including occasions in or around 2018 when doses of up to 7,200 mg gabapentin were prescribed.

(ii) During the period from in or around December 2015 to on or about February 1, 2016, Respondent described Patient C as making progress in terms of his alcoholism. However, Patient C missed appointments on or about February 5, 2016 and February 8, 2016. Further, on or about February 22, 2016, Respondent noted that Patient C returned to drinking and had a seizure 3-4 days prior, with hypotension and psychotic symptoms. Yet, Respondent failed to change his treatment plan, and there is no documentation of any effort by Respondent to obtain records of the patient's emergency room visit for the seizure. Also, Patient C missed the next appointment calendared for February 29, 2016. On or about March 7, 2016, Respondent reported that the patient had suffered a DUI "a month ago," and was intoxicated during the appointment,

and "tangential" on his mental status exam. Respondent also documented that another "specialist doctor" recommended a neuropsychological assessment, and that his attorney said he needed an MRI and neuropsychological assessment. Respondent also added a new diagnosis of "alcoholic dementia (wet brain syndrome)" on this date. However, there was no documentation in this note of an effort to communicate with this other specialist doctor, or the attorney, and no documentation of any cognitive assessment by Respondent, nor a referral for neuropsychological assessment to another practitioner. Further, Respondent failed to adjust his treatment plan for the patient; the same medications were continued, and he also prescribed a one month supply of lorazepam to aid in alcohol discontinuation, but without specific instructions on a tapering regimen.

(iii) Respondent also failed to recommend and/or document any recommendation for a higher level of care for safe detoxification followed by structured psychosocial rehabilitation. On or about March 14, 2015, Patient C cancelled an appointment because he overslept. Yet, Respondent still failed to document any assessment of any neuropsychological impairment issue.

(iv) On or about March 16, 2015, Patient C's assistant called Respondent and reported dangerous changes in the patient's status, including medication overdose, and Respondent recommended an emergency department assessment.

(v) On or about March 21, 2016 and March 28, 2016, Patient C failed to keep his scheduled appointments with Respondent. At the next appointment, on or about April 11, 2016, Respondent failed to follow up with the patient about his emergency department recommendation, or follow-up to obtain any emergency department records. Instead, Respondent merely continued the same medications as before, including lorazepam with no directions.

(H) In or around July 2015, and thereafter, Respondent's medical record keeping of his treatment of Patient C represents gross negligence. Respondent also committed gross negligence by failing to adequately assess and/or examine the patient (including by obtaining an adequate history and symptomology from the patient), and/or by failing to adequately document the same. The illegibility of Respondent's records would have made it extremely difficult for

another healthcare provider to review them. This is further complicated by his underuse of standard medical terminology in description of findings. In addition, the organization of Respondent's progress notes did not follow standard divisions of the medical assessment, despite the template for his notes. Respondent's documentation of care for Patient C involved the use of words, phrases and incomplete sentences. The information was also haphazardly organized in terms of its placement in the categories of the history, mental status examination, diagnosis and treatment Respondent included in his progress note template. For the principal diagnosis of alcohol use disorder/alcohol dependence, Respondent failed to adequately document any relevant changes in alcohol use patterns in the patient related to the prescribed interventions for the condition. Respondent also failed to adequately document his use of benzodiazepines in the patient. He failed to adequately document the patient's alcohol withdrawal symptoms. He also failed to adequately document his thought processes and evidence (symptoms) in support of any of his diagnoses, including for PTSD, bipolar disorder, MDD, dementia, and ADHD. He also failed to adequately document the patient's response to medical interventions.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

49. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts in the care and treatment of three patients. The circumstances are as follows:

50. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

51. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act. In addition, Respondent committed the following acts of negligence:

Patient A.

52. In or around December 2017 and thereafter, Respondent negligently failed to adequately manage his termination of his medical care for Patient A. He placed her at risk for benzodiazepine withdrawal by terminating his care for her and/or exacerbation of her illness,

including PTSD by not adequately providing recommendations for continuation of her medication and/or psychiatric treatment. Respondent had been prescribing benzodiazepines to the patient for years, and he should have realized that she would experience withdrawal symptoms by terminating her care in the manner he did.

53. In or around May 2014 and thereafter, Respondent negligently and incompetently continued his nonstandard treatment of Patient A for a condition outside his area of expertise (i.e., migraines), including through the use of prescription medications, despite his own repeated recommendation for consultation with, or transfer of care to, a neurologist. The records indicate several opportunities to assist the patient in obtaining this transfer/consultation. According to Patient A, Respondent told her that he was a medical doctor first and a psychiatrist second. Many of her prescriptions from Respondent were to treat her medical problem, viz., migraines. On or about September 21, 2015, Respondent prescribed propranolol (40 mg BID) to the patient for migraines or hypertension. In addition, his repeated prescriptions for Maxalt (a triptan used only for migraines) to her also indicates he was treating her as a primary care physician. He also repeatedly documented the prescription of Norco® to her for her migraines. At his First Interview, Respondent alleged that he repeatedly told her to get a primary care doctor or neurologist for her migraines from the beginning. Yet, he continued to treat her with medications. Further, he stated at his First Interview in connection with his mediation refill dated November 13, 2017, that Patient A would not come in person and that this was telemedicine because of her limited resources. He also failed to consider the possibility that her avoidance of a primary care doctor was maintained by his continuing to prescribe medication for her migraines. Respondent also failed to recognize that his care for Patient A exhibited a classic negative reinforcement paradigm,[17] viz., a tendency for avoidance in patients with PTSD that could be maintained, i.e., negatively reinforced, by his actions.

Patient B.

54. In or around April 2014 and thereafter, Respondent negligently prescribed drugs without indication and/or improperly managed Patient B's psychiatric conditions. He failed to

[17] Which is relevant to treatment of her PTSD because of the passive/mastery dynamic.

adequately assess and/or prescribe drugs to Patient B and/or document his rationales for his treatment of the patient.

(A) Respondent diagnosed Patient B, a 63-year-old man with "Major Depression with Anxiety" on or about February 9, 2004. However, his records fail to adequately document any description of any history of depressive episodes (although there is a notation that there was no history of suicide attempts or mania). Respondent noted that Patient B had a lifetime history of anxiety, related to a childhood episode of polio, and that he was "usually depressed and anxious." However, he failed to adequately document any current symptoms of any major depressive episodes.

(B) Patient B had a chronic history of depression. Respondent's records include repeated notes indicating that Respondent prescribed quetiapine as the "best" treatment for depression and insomnia. However, the patient discontinued quetiapine because it may have caused pancreatitis. Further, while quetiapine is indicated for bipolar depression, it is not indicated to treat unipolar depression. Moreover, Respondent's diagnosis of bipolar disorder in the patient changed over time. Respondent inconsistently included bipolar in his list of diagnoses (on or about October 14, 2016, November 1, 2018, December 4, 2018, February 12, 2019 and October 3, 2019). He also concluded on occasion that Patient B had no history of mania on or about October 31, 2019, March 3, 2020 [clearly never any mania] and June 11, 2020. This is important because lurasidon and Trileptal®[18] may have efficacy in some aspects of bipolar disorder, but none have a role in unipolar depression. Further, amitriptyline is contraindicated in bipolar depression because tricyclic antidepressants like amitriptyline have the greatest risk of antidepressant associated manic switch among antidepressant classes. Yet, Respondent failed to adequately perform an adequate diagnostic assessment for Patient B. Without a proper diagnosis, Respondent failed to engage Patient B in an adequate discussion about the optimal short and long-term medical treatment. If the patient did not have bipolar disorder, then Respondent should have informed the patient that his prescription for quetiapine was off-label, even if it helped with sleep and depression, particularly since TD can be caused or exacerbated by quetiapine.

[18] Which Respondent prescribed to the patient on or about April 3, 2019.

(C) Respondent documented Patient B's childhood experience with polio treatment and PTSD and used the terms CBT, DBT and PIOP to address that PTSD. However, he failed to adequately perform and/or document any of these treatments for the patient and/or whether or not any of these PTSD symptoms responded to these treatments. Respondent's records fail to elucidate whether the patient's sleep disturbance was a symptom of PTSD. Further, there was no documentation of either CBT specifically addressing that, nor consideration of evidence-based medications (fluoxetine, paroxetine, sertraline or venlafaxine, VA/DoD 2017) in lieu of the sleep medications and antipsychotic medications.

(D) At a patient encounter on or about August 4, 2016, Respondent noted that the patient was sick and on lithium. He diagnosed him with "Manic Depression." The patient had a history of prior treatment with trazodone, mirtazapine, and ElavilR® (amitriptyline). Prescriptions for Ambien® and Sonata® were documented. The patient had also received dissolvable tablets of Zydis® (olanzapine) during a time in the hospital which had occurred an unspecified time before. His plan was to consider Tegretol, Trileptal® (oxcarbazepine) and Depakote®, and the patient was continued on mirtazapine, Ativan®, rozerem and "gabapentin 100 mg/d for mood disorder," while lithium was discontinued. However, gabapentin is not indicated for the treatment of bipolar disorder, and an abrupt discontinuation of lithium increases the risk of an emergent new mood episode, and of suicide. Thus, the patient was placed on antidepressant monotherapy (mirtazapine) which would have placed him at risk of mania or mood destabilization.

Patient C

55. In or around July 2015, and thereafter, Respondent committed negligence by failing to adequately assess, re-assess and manage Patient's C's health issues and treatment, including his dangerousness to himself and others. Respondent failed to address the information before him about Patient C's dangerousness and/or analyze his risk level and/or refer him to intervention such as emergency services and/or hospitalization. In or around April 2016, Respondent received information that Patient C had been in three car accidents, was still driving, and had been buying "stupid things" and playing with guns after receiving a $500,000.00 settlement. The patient's

brother and his son feared for the life of the patient. The patient's son said that they had "locked up the guns."

56. On or about July 2015, and thereafter, Respondent negligently and incompetently diagnosed co-morbid conditions in Patient C, without performing adequate medical assessments and re-assessments, and/or documenting his findings.

(A) Respondent repeatedly diagnosed Patient C with PTSD, but failed to adequately document any trauma history, or symptoms from this diagnosis, including nightmares and flashbacks, trauma-related avoidance behavior, alterations in thinking and feelings related to the trauma or hyperarousal symptoms such as increased startle reaction or hypervigilance.

(B) Respondent also repeatedly diagnosed Patient C with ADD, but failed to adequately document a developmental history of symptoms or current symptomatology for that diagnosis in any detail or in a way that corresponds to standard terminology. Further, on or about July 25, 2016 when he prescribed Strattera® (atomoxetine, a noradrenaline-selective reuptake inhibitor antidepressant like agent, FDA indicated for ADHD in adults) to the patient, Respondent failed to adequately consider the likely possibility that Patient C's alcohol misuse could explain his impairments in concentration.

(C) On or about March 7, 2016, Respondent diagnosed Patient C with dementia, specifically alcohol dementia, "wet brain," without recording any specific examination of cognitive functioning, which is required for a diagnosis of dementia.

(D) On or about January 3, 2018, Respondent diagnosed Patient C with bipolar I disorder, and discontinued the patient's prescription for fluoxetine because of this diagnosis. However, he failed to document any current or past episode of mania or hypomania, which is required for the diagnosis. He also failed to discuss and/or document his discussion with the patient regarding the diagnosis, and acute and long-term treatment and options. Respondent also prescribed a very high dose of Seroquel (presumably to address mania). If Respondent was treating an acute full blown manic episode, specific aspects of safety (poor decision making such as impulsive spending) and their management (asking for the patient's permission to involve family members to limit patient's access to large sums of money; limit impulsive engagement in

potentially dangerous behavior, etc.) should have been discussed with the patient and documented. He also failed to adequately monitor for medication effects, including adverse effects such as sedation (in combination with lorazepam and gabapentin and divalproex) and metabolic syndrome and cardiac rhythm disturbances in the patient.

(E) On or about February 5, 2018, Respondent failed to document any specific discussion regarding the apparent manic episode documented in the January 3, 2018 progress note or its resolution. He resumed the patient's prescription for Prozac®.

57. On or about July 2015, and thereafter, Respondent negligently prescribed dangerous drugs to Patient C without adequately documenting information regarding the diagnosis and/or the condition being treated. Respondent failed to adequately document which specific diagnoses he was treating with specific medications, and/or failed to adequately monitor and/or document the effects of his treatment on the symptoms of each diagnosis through his continuous prescribing of medications.

(A) On or about January 30, 2017, Respondent prescribed Strattera® (atomoxetine) to the patient "to start for attention," without adequate documentation of any symptoms or history of ADHD for which this medication was indicated.

(B) On or about December 15, 2015, Respondent prescribed lisinopril, an antihypertensive medication, to Patient C and continued prescribing this through in or around 2018. However, Respondent failed to document a diagnosis of hypertension. Further, he only documented the patient's blood pressure on or about February 22, 2016.

(C) Respondent prescribed atorvastatin, a cholesterol/lipid lowering medication, multiple times without documenting a diagnosis or any laboratory findings.

58. On or about July 2015, and thereafter, Respondent negligently released private health information about Patient C without authorization.

(A) On or about November 13, 2017, Respondent wrote a letter to Patient C and S.M., LCSW, LAC Counselor (sic) Kalispel, Montana, in which he described the patient's completion of courses at Flathead Valley Clinic. The letter discussed a description of the patient's alcoholism diagnosis.

(B) On or about April 18, 2018, Respondent wrote a five-page letter discussing the patient's treatment for alcoholism and electronically transmitted the letter to the patient as well as to his primary care physician and alcohol abuse counselor. A request for authorization was also transmitted to the patient, who did not sign it.

59. On or about July 2015, and thereafter, Respondent negligently failed to attempt to obtain and/or review pertinent information about other treatments that Patient C received from other medical providers/institutions. Respondent failed to adequately follow up and attempt to obtain records from the "specialist doctor" that the patient saw after his DUI in or around February 2016 and from the emergency department in connection with his emergency room visit recommendation due to the deterioration in the patient's clinical status. On or about February 5, 2018, Patient C had a patient encounter with Respondent after completion of the "Watershed" alcoholism residential treatment program in Del Ray Beach, Florida. However, Respondent failed to adequately follow up or attempt to obtain copies of records from that treatment program. Additionally, Respondent resumed prior medications for the patient, despite the patient having told him there had been changes made in his medications during his treatment program at "Watershed." In or about July 2016, the patient suffered from a severe relapse in his alcoholism. He had been drinking all day and vomiting all night and went to the emergency room. He reportedly had a new medical doctor at this time. However, Respondent failed to adequately follow up with the patient and request more information about and from this doctor, including his specialty. He failed to pursue whether this new doctor could take over care of the patient.

60. On or about July 2015, and thereafter, Respondent negligently failed to adequately perform and/or document an informed consent with Patient C, which should have included information about benefits and risks of his proposed treatments and alternatives (including any off-label treatments, e.g., based on high dosage or non-indicated uses of medications). Respondent repeatedly prescribed to Patient C, gabapentin, quetiapine and divalproex without documented FDA indications. In addition, he prescribed other medications (e.g., Strattera® and lithium) to the patient at times, with no documentation about informing the patient about potential side-effects.

61. On or about July 2015, and thereafter, Respondent negligently failed to recognize his potential to influence boundary violations when treating Patient C. Respondent, as a psychiatrist, should have adequately recognized his potential to influence the unconscious dynamics (transference and countertransference) which influence treatment, and/or should have taken precautions to avoid interpersonal boundary violations. The patient was referred to him by his father, a family physician. In a letter entitled, "Dear Ihor," dated May 21, 2018, Patient C wrote to Respondent stating that his understanding was that their relationship was both personal and professional, similar to the relationship Patient C asserts he had with Respondent's father. Patients with substance use disorders are known to use such boundary violations in order to influence a doctor's assessment and treatment: reduced attention to safety of patients' substance use related problems; and increased likelihood of prescribing controlled substances.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

62. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that Respondent was incompetent in the care and treatment of patients. The circumstances are as follows:

63. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

64. Respondent practiced outside his area of expertise.

65. Respondent's treatment of the patients above represents incompetence, including in connection with Patient C:

(A) When he repeatedly diagnosed the patient for PTSD but failed to adequately assess and/or document the patient's trauma history and/or symptoms.

(B) When he discussed treatments with Patient C in a medically unsupported way.

(i) On or about January 11, 2016, Respondent documented the use of ECT (Electro-Convulsive Therapy), which is considered "for mood," but the Mood and Affect are characterized in the note as "less depression." Respondent added a Major Depression diagnosis to Axis I without any documentation of current depressive symptoms, prior history of episodes,

prior treatments for depression, family history of mood disorder, and, in particular about how the Major Depressive Disorder condition had been distinguished from depressive symptoms that are associated with symptoms of severe alcohol use disorder. ECT is indicated for treatment-refractory severe major depression, or urgently life-threatening major depression, and some other specific conditions not present.

(ii) Under a category in the chart entitled "TREATMENT/ COUNSELING GOALS," most categories of treatment are checked in the majority of Respondent's notes. These include the two categories of "Cognitive Em Behavioral Psychotherapy (trauma focused)" and "Psychodynamic Insight Oriented Psychotherapy." These are two types of psychotherapy with specific indications, training requirements and systematic, dedicated treatment approaches. They can be used in the same patient for different indications, but not simultaneously. There is no evidence in the record that Respondent conducted either type of psychotherapy with Patient C. There were several notes where conducting either of these types of psychotherapy would be contraindicated, such as on or about March 29, 2018 when the patient was actively drinking during the session.

(iii) On or about November 21, 2016, Respondent documented "Parnate" (tranylcypromine) without explanation. This Monoamine oxidase inhibitor antidepressant (MAOI) is used today, but only in very selected cases of major depression because it requires careful systematic assessment and management of a complex array of potential side-effects and risks--including the fact that it is absolutely contraindicated in conjunction with either Strattera® or citalopram, both of which Respondent was currently prescribing to Patient C. Similarly, on or about March 10, 2017, Respondent documented "Consider MAOI" with no discussion about this treatment.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

66. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to a patient. The circumstances are as follows:

67. The allegations of the First, Second and Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

68. Respondent's medical records for each of the patients alleged herein contain writing that is very difficult to read and at times totally illegible.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination and Excessive Prescribing)

69. Respondent is subject to disciplinary action under sections 2242 and 725 of the Code, in that Respondent prescribed drugs to the three patients above, without appropriate prior examinations and/or medical indications and/or excessively prescribed medications. The circumstances are as follows:

70. The allegations of the First, Second, Third and Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

71. Respondent is subject to disciplinary action under Code section 2234, in that his action and/or actions represent unprofessional conduct, generally and patient harm occurred as a result. The circumstances are as follows:

72. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 62655, issued to IHOR ANTON MICHAEL GALARNYK, M.D.;

2. Revoking, suspending or denying approval of IHOR ANTON MICHAEL GALARNYK, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering IHOR ANTON MICHAEL GALARNYK, 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: MAR 17 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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