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

In the Matter of the Accusation Against: **Bernard Michael Kirzner, M.D.** **6345 Balboa Blvd., Suite 245** **Encino, CA 91316-1580** **Physician's and Surgeon's Certificate No. C 35243,** Respondent.	Case No. 800-2018-043001 **ACCUSATION**

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 July 23, 1973, the Medical Board issued Physician's and Surgeon's Certificate Number C 35243 to Bernard Michael Kirzner, 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 February 28, 2023, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the

physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. 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.

STATUTORY PROVISIONS

7. 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.

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. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

DEFINITIONS

10. Alprazolam (Xanax) is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(l) and dangerous drug as designated by Business and Professions Code section 4022. It is used to treat anxiety and panic disorders.

11. Duloxetine (Cymbalta) is categorized as a dangerous drug pursuant to section 4022. It is an antidepressant approved to treat mood and pain disorders.

12. Lamotrigine (Lamictal) is a dangerous drug as designated by Business and Professions Code section 4022. It is an antihypertensive drug.

13. Carisoprodol (Soma) is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d), and is a dangerous drug as designated by Code section 4022. It is used to treat muscle spasms.

14. Quetiapine (Seroquel) is an antipsychotic drug. It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

15. Levomilnacipran (Fetzima) is approved to treat major depressive disorder. It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

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16. Desyrel (trazodone) is a dangerous drug within the meaning of Business and Professions Code section 4022, and used for the treatment of depression.

17. Zofran (ondansetron) is used to prevent nausea and vomiting that may be the result of surgery or cancer treatment. It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

18. Orphenadrin (Norflex) is a dangerous drug pursuant to Business and Professions Code section 4022. It is used as a muscle relaxant.

19. Catapres (clonidine) is a dangerous drug within the meaning of Business and Professions Code section 4022, and used for the treatment of hypertension.

20. Vistaril (hydroxyzine) is a dangerous drug pursuant to Business and Professions Code section 4022. It is a prescription medicine used to treat the symptoms of anxiety, itching or hives on the skin, and as preoperative sedation.

21. Belsomra (suvorexant) is a sleep medicine used to treat insomnia that has some potential for abuse. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Venlafaxine (Effexor) is a dangerous drug under Business and Professions Code section 4022. It is used to treat depression.

23. Mirtazapine (Remeron) is a dangerous drug under Business and Professions Code section 4022. It is used to treat depression.

24. Ziprasidone (Geodon) is a dangerous drug as designated by Business and Professions Code section 4022. It is a drug used to treat schizophrenia and mania.

25. Guanfacine is in a class of medications called centrally acting alpha2A-adrenergic receptor agonists. Guanfacine treats high blood pressure by decreasing heart rate and relaxing the blood vessels so that blood can flow more easily through the body.

26. Evekeo is a central nervous system stimulant prescription medicine used for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD). It is an amphetamine and dextroamphetamine sulfate, a Schedule II controlled substance as designated by Health and

Safety Code section 11055, subdivision (d)(1), and a dangerous drug as designated by Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

PATIENT 1

27. In or around March 2009, Respondent commenced caring for Patient 1.[1] His diagnoses included major depression, recurrent, in remission; and possible bipolar with a past history of cocaine use. Respondent continued his treatment of Patient 1 for the next ten years.

28. On or about May 13, 2014, as noted in Respondent's chart for Patient 1, Respondent saw the patient, noting a diagnosis of Bipolar II Disorder, depression in partial remission and Panic Disorder with Agoraphobia. He prescribed the patient alprazolam. At the bottom of the chart note there is a signature with an earlier date of April 22, 2014. There was no documentation of informed consent for the prescription of alprazolam. Respondent did not seek any records or consultations with the patient's current or prior treating providers, including her psychologist.

29. Respondent provided to the Medical Board two sets of certified medical records for Patient 1 which contained inconsistencies; both sets contained lengthy gaps in the record of treatment of Patient 1. Both included inconsistent formatting, including typed notes; handwritten notes; note templates completed in handwriting; notes written on otherwise blank pages; notes written on other documents such as medication lists, electronic prescription records and memo pads; and multiple notes on one page. In some instances, one version contained a typewritten note while the other version for the same date included a handwritten addition which was not dated or signed. Medication reconciliation is inconsistent throughout the medical record with omissions not only of Respondent's medications but of medications prescribed concurrently by other providers.

30. On or about June 5, 2014, Respondent saw the patient and noted that she was in a day treatment program at "Northridge HMC Psychiatry" after overdose with medicines. Her medications were documented as clonazepam as well as Lamictal, Lexapro, Neurontin

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[1] The patients herein are referred to by number to help ensure their privacy.

(gabapentin) and buspirone, an anxiolytic. The chart note has a signature under the date of September 22, 2014.

31. The complaint filed with the Medical Board regarding Patient 1 indicated that she had a suicide attempt by alprazolam on August 19, 2014.

32. On or about August 19, 2014, Respondent hand wrote a note on a June 24, 2014, chart note indicating that the patient's daughter had reported the patient was taken by ambulance to the hospital for a possible overdose. Respondent noted that he refused to provide the daughter with the medications the patient was on and advised her to have the emergency room doctor call him.

33. On or about September 16, 2014, Respondent saw the patient and documented the circumstances of the overdose incident based on the patient's report, noting the involvement of alprazolam. He noted that the patient was able to get off alprazolam while hospitalized. He planned to increase Lamictal. He also planned to increase alprazolam for one week and wrote a prescription for it while tapering two non-controlled substances, gabapentin and buspirone. There continued to be no documentation of informed consent for the prescription of alprazolam. Respondent did not seek any records or consultations with current or prior treating providers, including her psychologist.

34. On or about September 19, 2014, Respondent documented that post hospitalization the patient could be prescribed a minimal amount of clonazepam.

35. On or about November 18, 2014, after discontinuing gabapentin, Respondent wrote a prescription for the controlled substance carisoprodol, a muscle relaxant with no psychiatric indication and not typically prescribed by a psychiatrist not specializing in pain management. Respondent did not document the initiation of this medication nor his rationale for prescribing it. There was no documentation of informed consent for the prescription of carisoprodol.

36. On or about March 10, 2015, carisoprodol first appears on Respondent's medication list for the patient despite having been prescribed since November 2014. Alprazolam was increased to 1 mg daily on or about February 10, 2015, but is documented on the medication list for this date as 0.5 mg, once at night "but not every night." There was no documentation of

informed consent for the prescription of alprazolam. Respondent did not seek any records or consultations with current treating providers, including her psychologist.

37. On or about June 8, 2015, Respondent documented that the patient feels "A little guilt about the benzodiazepine usage. Take medicines, but at night usually take them." The medication list for this date included clonazepam 1 mg and later added carisoprodol for neck cramps, "issues," and "Relaxing." There was no documentation of informed consent for the prescription of clonazepam or carisoprodol.

38. On or about September 29, 2015, Respondent typed a detailed progress note identifying a new stressor in the patient's life, the suicide by gun of her brother a month earlier. His diagnosis was noted as "Major Depressive Disorder, mild to moderate, recurrent, without psychosis."

39. On or about May 3, 2016, a medication list for Patient 1 included both carisoprodol and clonazepam, increased to 4 mg/day. There was no documentation of informed consent for the prescription of clonazepam or carisoprodol. Respondent did not seek any records or consultations with current treating providers, including her psychologist.

40. On or about July 13, 2016, a handwritten completion of a printed template documented a diagnosis of "MDD [major depressive disorder] or Bipolar II" as well as "Drug & medicine Usage Disorder" without explaining the diagnoses. Also, the patient was now prescribed the highly addictive, short acting benzodiazepine alprazolam with no mention of the longer acting benzodiazepine clonazepam. There was no documentation of informed consent for the prescription of alprazolam.

41. On or about January 24, 2017, Respondent's handwritten note on a printed medication list noted the continued prescription of clonazepam 1 mg 4 times a day and stated, "High stress with Bro[ther] & Ma [mother]'s estates. Trying to limit med usage despite this. Tried to convince her this is not the time to try less meds." There was no documentation of informed consent for the prescription of clonazepam. Respondent did not seek any records or consultations with current treating providers, including her psychologist.

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42. On or about April 25, 2017, Respondent noted in the chart a mental status change based on a phone call with Patient 1, whom he noted was "Oversedated, speech slurred. Family says hallucinating. Advised to [discontinue] Quetiapine & leave Fetzima" and call the next day.

43. On or about April 26, 2017, another individual noted in the chart that the patient was crying and that the family is concerned and believes the patient is hallucinating. The family was advised to lower the dosing of the medicine. Respondent did not seek any records or consultations with current treating providers, including her psychologist.

44. On or about May 30, 2017, Respondent noted that the patient was depressed but not suicidal and reported, "Can't use Soma or Clonazepam, doesn't do much, calming a bit, no help with mood."

45. On or about May 31, 2017, a handwritten note documents that the patient has decided to seek care at the Northridge hospital where she was treated before.

46. The complaint filed with the Medical Board regarding Patient 1 indicated that she had returned to Northridge hospital in August 2017 and was detoxified from clonazepam and carisoprodol.

47. On or about September 16, 2017, a typewritten note with Respondent's handwritten signature noted that the patient had called "seemingly drunk (which she denies) or overly sedated. Claims she took unknown chemical from neighbor but no alcohol or prescription drug." The note continued, "Speech slurred confused, disoriented as to date, but adamant that she just needs to sleep." The patient was advised to discontinue her most sedating drug, carisoprodol, and call the next day. Respondent noted he planned to call the patient the next day and if it did not clear during the course of the day, he would advise her to go to an urgent care for evaluation and testing.

48. On or about October 3, 2017, Respondent charted a completed "Young Mania Rating Scale" in which the patient was not found to be manic. The form was provided by a pharmaceutical company that made Adderall.

49. On or about October 10, 2017, a typed progress note with handwritten additions noted the patient was attending Northridge Hospital three times a week, "can't sleep [not taking

[clonazepam]," with a mental status assessed as "Attention and concentration were fair," and "No changes in treatment indicated. . . yet." Respondent did not seek any records or consultations with current or prior treating providers, including her psychologist.

50. On or about October 18, 2017, Respondent documented that Patient 1 was "Not depressed when on Clonazepam" and "Very anxious without Clonazepam. Worked fine ONGOIOING [sic]." Respondent prescribed 90 tablets of clonazepam 1 mg three times daily and wrote, "know just that there helped, just knowing that it was there." He also documented that carisoprodol had been discontinued in favor of a heating pad and chiropractor. There was no documentation of informed consent for the prescription of clonazepam.

51. On or about November 3, 2017, Respondent documented that the patient was continuing intensive outpatient care and is rarely taking clonazepam.

52. On or about November 8, 2017, Respondent prescribed sixty tablets of carisoprodol 350 mg twice daily per an original script. There was no corresponding progress note noting the prescription and explaining why it was restarted after the patient discontinued it in favor of non-pharmacological pain management interventions. There was no documentation of informed consent for the prescription of clonazepam.

53. On or about April 30, 2018, Respondent in a handwritten note, documented that the patient was unable to stay away from prescription medications such as Vicodin or sleep medications. He noted that while she had decreased the use of benzodiazepines, their use was still a problem and that the patient had looked into an inpatient detox program at Cliffside Malibu, which he strongly encouraged.

54. On or about May 3, 2018, a typed note with handwritten additions, noted in type that the "family against clonazepam," "Clonazepam: need to sleep," "Denies using the [carisoprodol]." Handwritten additions included: "Unsteady gait. . .thinking concrete, unable to read medication chart and understand only one day. . . fears going to Cliffside Malibu for treatment & detox for a month. . . Delirium. 2mg/day clonazepam for 5/4 5/5 only. Admit to Cliffside Malibu."

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55. On or about June 8, 2018, Respondent documented that the patient had spent one month in the rehabilitation hospital, was detoxified with phenobarbital over ten days and concludes "no more clonazepam, no more [carisoprodol]." A second typewritten note of the same date documented Cliffside Malibu Discharge Medications to include Trazodone 100 mg; Zofran (ondansetron); Orphenadrin; Catapres (clonidine); Vistaril (hydroxyzine) 25 mg BID. The chart also included a May 29, 2018, note from an addiction medicine specialist with diagnoses of Sedative, hypnotic, or anxiolytic use disorder; Bipolar I disorder, severe; and Generalized anxiety disorder.

56. On or about June 23, 2018, Respondent in a typed note with handwritten additions, stated that his diagnosis was Bipolar II disorder not Bipolar I Disorder because he did not believe that the patient had full manic episodes; he also confirmed that she was no longer taking benzodiazepines. A second typed note for the same date documented, "Uses the clonazepam to relax, and to sleep."

57. On July 2, 2018, Respondent repeated the Young Mania Rating Scale that was also insignificant and this time on a different drug company preprinted form.

58. On or about February 15, 2019, Respondent documented that he was once again prescribing clonazepam 1 mg at bedtime for insomnia. He did not document his rationale. Respondent's chart included a CURES patient activity report document for Patient 1 which shows his prescription of clonazepam 1 mg, 30 tablets each on January 18, 2019, February 12, 2019, March 9, 2019 and April 16, 2019. The CURES report also reflected Respondent's prescription of another Schedule IV medication for insomnia for Patient 1: 30 tablets of Belsomra (suvorexant) 20 mg po on March 25, 2019, and April 26, 2019. Respondent prescribed clonazepam 1 mg twice daily on August 7, 2019, and up to three times daily (twice scheduled and a third as needed) on October 19, 2019. There was no documentation of informed consent for the prescriptions of clonazepam and suvorexant.

59. Respondent's prescribing practice with Patient 1 resulted in substantial harm to the patient by contributing to the development and perpetuation of a substance use disorder; by inadequately treating both a co-morbid anxiety disorder and co-morbid Sedative, Hypnotic, and

Anxiolytic Use Disorder; by contributing to a psychiatric emergency of a suicide attempt by overdose of alprazolam, a sedative/hypnotic/anxiolytic medication; and by contributing to a medical emergency of delirium.

PATIENT 2

60. On or about June 13, 2001, Respondent began treating Patient 2. Respondent's note for this visit did not document a psychiatric evaluation, psychiatric diagnosis, or mental status examination. The note details the high doses of two non-controlled psychotropic medications used for depression/anxiety and insomnia that Patient 2 was receiving, respectively, venlafaxine (Effexor) and trazadone (Desyrel), and details a supportive history for those medications. Respondent's note then stated, without an appropriate clinical basis, that Patient 2 had Attention-Deficit/Hyperactivity Disorder (ADHD) (for which a controlled substance stimulant medication is the first-line treatment.) Respondent discontinued the venlafaxine and trazadone thereafter and treated the patient for 19 years for ADHD while paying no clinical attention to depression, anxiety or insomnia. Respondent did not document an appropriate informed consent for the treatment of ADHD with controlled substances (stimulants and benzodiazepines).

61. Respondent provided certified medical records for Patient 2 which contained inconsistencies; lengthy gaps in the record of treatment of Patient 2; inconsistent formatting, including typed notes; handwritten notes; note templates completed in handwriting; notes written on otherwise blank page; notes written on other documents such as medication lists, electronic prescription records and memo pads; and multiple notes on one page. Typed notes frequently were not signed or dated, and were missing pages. Medication reconciliation was inconsistent throughout the medical record with omissions not only of Respondent's medications, but of medications prescribed concurrently by other providers.

62. On or about April 11, 2014, Respondent noted that he had obtained a mental residual functional capacity questionnaire from Patient 2 and dictated a note on it. The note's signature was typewritten as May 3, 2019, the same erroneous date on three earlier progress notes from 2005. The date has a handwritten correction dated April 14, 2014, but not signed. The dictated note has no heading and no date but has the patient's name at the bottom. It states a diagnosis of

major depression, recurrent, moderate to severe, chronic without psychosis. It states that the diagnosis is disabling by itself and also due to chronic lowered self-esteem, energy, motivation, interest in things, loss of pleasure in things, lowered concentration or pessimism. The note indicates that virtually every antidepressant and adjunctive medication had been tried without success. Respondent did not document an appropriate informed consent for the continued treatment of ADHD with controlled substances (stimulants and benzodiazepines).

63. On or about February 19, 2016, in response to the Social Security Administration denying Patient 2's March 7, 2014, application for disability based on his ADHD diagnosis, Respondent wrote a note describing Patient 2's ADHD. The denial had indicated that the claim was not consistent with the medical record as a whole, in which the treatment records were insufficient to support the requested work restrictions. It noted the Respondent's opinion was quite conclusory and provided very little explanation of the evidence relied on in forming the opinion. Respondent's rebuttal in the chart cited Patient 2 circumstances that did not appear elsewhere in medical record.

64. On or about April 6, 2016, the next progress note is made, although Respondent was treating the patient in the meanwhile. The note is addressed to the patient and states the patient will have serious psychiatric symptoms with no relief in sight, including ADHD, serious depression, and anxiety. The note further states that the patient had been on so many ADHD medicines with either failure or side effects that the prognosis was very negative. The note also states that the three psychiatric conditions and their disabilities were likely to continue through the rest of the patient's life. Respondent did not document an appropriate informed consent for the continuing treatment of ADHD with controlled substances (stimulants and benzodiazepines).

65. On or about May 4, 2016, Respondent wrote an unsigned summary letter entitled, "Medical records for [Patient 2] October 31, 2014 – April 29, 2016," apparently intended to enhance the medical record for an ADHD diagnosis.

66. On May 6, 2016, an Adult ADHD Self-Report Scale Symptom Check List was completed.

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67. On or about May 10, 2016, a signed letter describing the patient's "mental impairment" was added to the chart.

68. On or about June 1, 2016, Respondent saw the patient. The progress note typed on a template does not document any prescribed medications for ADHD.

69. Between on or about July 16, 2016, and April 12, 2017, significant documentation in the chart includes: (1) a medication list dated July 6, 2016, that includes alprazolam and dextroamphetamine/amphetamine with no accompanying progress note; (2) a handwritten notation dated July 15, 2016, that includes a prescription for a further antipsychotic medication, Geodon (ziprasidone), with no explanation or accompanying progress note; (3) a handwritten note with no name dated April 12, 2017, describing the discontinuance of the non-controlled substance ADHD medication, guanfacine (approved for children ages 6-17) due to the known adverse effect of hypotension, especially applicable in adults; and (4) an April 12, 2017, typed schedule of medications, without an accompanying progress note, revealing a new Schedule II ADHD medication, Evekeo (amphetamine). Respondent did not document an appropriate informed consent for the continued treatment of ADHD with controlled substances (stimulants and benzodiazepines).

70. On or about July 22, 2017, Patient 2 emailed Respondent referencing two errors on a July 19, 2017, spreadsheet from Respondent listing his medications. The spreadsheet indicated the patient was taking alprazolam four times a day, morning, noon, afternoon, and bedtime.

71. On or about August 20, 2017, Respondent received an undated note from a pharmacy stating that a review of Respondent's prescriptions for anxiolytics or sedative agents caused concern that patients were taking more than originally prescribed, which could lead to adverse effects including drowsiness, fatigue, and impaired cognition. Respondent wrote on the note that he had repeatedly discussed sedation by multiple CNS medications with Patient 2, who had no falls, broken bones, or concussions while on the meds in the last ten years.

72. On or about September 6, 2017, Respondent noted that the patient got depressed and fell off his chair again so the patient increased the Xanax and Remeron, which did not help.

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Respondent did not document an appropriate informed consent for the continued treatment of ADHD with controlled substances (stimulants and benzodiazepines).

73. Between on or about February 2, 2018, and December 12, 2018, the patient's chart included: (1) handwritten notes documented on a computer printout of medications dated February 2, 2018; (2) handwritten notes with no patient name dated March 29, 2018, June 20, 2018, and December 12, 2018; (3) an April 18, 2018, typed medication list with no patient name with excessive doses of controlled substances: prescriptions needed, Evekeo (amphetamine) .5 mg dosage 4/day 90 day supply #360; Xanax (alprazolam) .5 mg dosage 4/day 90 day supply #360; and Xanax 1.0 mg dosage 4/day 90 day supply #360; (4) a September 26, 2018, typed, unsigned, and incomplete progress note identifying for the first time Patient 2's primary care provider; referencing the patient's brief periods of weakness in legs bilaterally; and indicating the patient is off walking for a long time; (5) a July 25, 2018, notation of balance problems and trouble with ladders and step stools; and (6) no documentation of an appropriate informed consent for the continued treatment of ADHD with controlled substances (stimulants and benzodiazepines).

74. Respondent's prescribing practice with Patient 2 resulted in substantial harm to the patient by contributing to the development and perpetuation of two substance use disorders (i.e., Stimulant Use Disorder and Sedative, Hypnotic, and Anxiolytic Use Disorder); and by prioritizing the treatment of alleged ADHD without substantiating this clear psychiatric diagnosis and medical indication over the patient's co-morbidities of major depressive disorder and anxiety disorder.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

75. Respondent Bernard Michael Kirzner, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the psychiatric care and treatment of patients. The circumstances are as follows:

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PATIENT 1

76. The facts and circumstances alleged in paragraphs 27 through 59 above are incorporated here as if fully set forth.

77. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent in failing to include in his diagnosis and treatment plan for Patient 1 (including collaboration with the patient's concurrent psychotherapist) two interrelated co-morbid psychiatric disorders: (1) an anxiety disorder; and (2) a Sedative, Hypnotic, and Anxiolytic Use Disorder.

78. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent in failing to incorporate previous and concurrent information from medical records and providers to inform his evaluation, diagnosis, formulation and treatment planning for Patient 1.

79. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent in disregarding Patient 1's desire to minimize the use of controlled substances, which had the potential for acquiring and perpetuating addiction.

80. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent in failing to obtain and document informed consent for prescribing controlled substances and psychotropic medications with an increased risk of developing and perpetuating a substance use disorder.

81. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent when he prescribed sedative/hypnotic/anxiolytic benzodiazepine medication to a patient with Sedative, Hypnotic, and Anxiolytic Use Disorder after three detoxifications.

82. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent when he prescribed to Patient 1, a patient with a substance use disorder, a Schedule IV muscle relaxant, carisoprodol, which is outside the scope of psychiatric practice, for insomnia.

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83. On or about April 25 2017, and September 16, 2017, Respondent was grossly negligent when, in the face of medical and psychiatric emergencies, he failed to ensure that Patient 1 received emergency medical and psychiatric evaluations, including an assessment for a suicide attempt, in light of the patient's prior attempted suicide by medicine.

84. Between in or around April 2014, through in or around October 2019, Respondent was grossly negligent when he failed to maintain accurate medical records.

PATIENT 2

85. The facts and circumstances alleged in paragraphs 60 through 74 above are incorporated here as if fully set forth.

86. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records, including inaccurate medical record-keeping in format, chronology, signature and non-contemporaneous with the service provided and the failure to properly document medication reconciliation.

87. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed a stimulant medication without indication.

88. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed benzodiazepines for anxiety in lieu of alternative, non-addictive medications.

89. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed atypical antipsychotics without indication.

90. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed multiple controlled substances (i.e., stimulants and benzodiazepines) with the potential for psychological and physiological addiction without obtaining informed consent.

91. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed atypical antipsychotics without obtaining informed consent.

92. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed benzodiazepine medication, stimulant medication and antipsychotic medication without appropriate monitoring for adverse effects.

93. Between in or around April 2014, through in or around December 2019, Respondent was grossly negligent when he prescribed stimulants and benzodiazepines in unsafe combinations.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

94. Respondent Bernard Michael Kirzner, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he engaged in repeated negligent acts in the psychiatric care and treatment of patients. The circumstances are as follows:

95. The facts and circumstances alleged in paragraphs 27 through 74 above are incorporated here as if fully set forth.

96. The allegations set forth in paragraphs 75 through 93 above are realleged here as repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

97. Respondent Bernard Michael Kirzner, M.D. is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of the medical services he provided to patients. The circumstances are as follows:

98. The facts and circumstances alleged in paragraphs 27 through 74 above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

99. Respondent Bernard Michael Kirzner, M.D. is subject to disciplinary action under section 2234 of the Code in that Respondent engaged in unprofessional conduct in the psychiatric care and treatment of patients. The circumstances are as follows:

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100. The facts and circumstances alleged in paragraphs 27 through 98 above are incorporated here as if fully set forth.

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 C 35243, issued to Bernard Michael Kirzner, M.D.;

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

3. Ordering Bernard Michael Kirzner, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Bernard Michael Kirzner, M.D. to provide disclosure to his patients that includes his probation status pursuant to Business and Professions Code section 2228.1; and

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

DATED: APR 05 2021

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

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