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

In the Matter of the Accusation Against: **GREGORY L. GORSKI, M.D.** **834 Milan Avenue** **South Pasadena, CA 91030** **Physician's and Surgeon's Certificate No. G 15977,** Respondent.	Case No. 800-2018-044578 **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 October 31, 1968, the Medical Board issued Physician's and Surgeon's Certificate Number G 15977 to Gregory L. Gorski, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, 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.
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> (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 2228.1 of the Code, states in pertinent part:

> (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.

7. 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. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(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 the patient's 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.

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 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.

10. Health and Safety Code section 11165.1, subdivision (a) states, in pertinent part:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

11. 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

"Abilify" is a brand name for aripiprazole, which is an atypical antipsychotic medication. It is primarily used in the treatment of schizophrenia and bipolar disorder. Other uses include as an add-on treatment in major depressive disorder, tic disorders and irritability associated with autism. It is a dangerous drug as defined in Business and Professions code section 4022.

"Adderall®" is a brand name of a combination of two stimulant drugs, amphetamine and dextroamphetamine. It is generally used to treat attention deficit hyperactivity disorder, but also has a high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

"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).

"Ambien®" see zolpidem.

"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.

"Carisoprodol" is a muscle-relaxant and sedative. It is sold under the brand

name "Soma®." 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.

"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.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III and IV controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from all Schedule II, III and IV controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of Schedule II, III and IV drugs. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more potent 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.

"Hydroxyzine" is an antihistamine medication, used to treat anxiety, nausea, vomiting, allergies, skin rash, hives, and itching. It can also be used with anesthesia before medical procedures. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Klonopin®" see clonazepam.

"Lisdexamfetamine" is a stimulant used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. It is a psychostimulant prodrug of the phenethylamine and amphetamine chemical classes. It is sold under the brand name Vyvanse®. It is a dangerous drug as defined in 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.

"Methylphenidate" is a central nervous system stimulant medication primarily

used to treat symptoms of attention deficit hyperactivity disorder (ADHD). It may also be used to treat narcolepsy. It is sold in its various forms under the following brand names: Concerta®, Ritalin®, Daytrana®, Aptensio XR®, Metadate CD®, Methylin®, Quillivant XR®, Jornay PM®, Adhansia XR and Cotempla®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Restoril®" is a brand name for temazepam, which is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. 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.

"SOAP" is an acronym for Subjective, Objective, Assessment and Plan, which is a method of organizing medical records commonly used by healthcare providers. Each component is defined below:

> Subjective. This section documents the patient's "subjective" experiences and information. It includes the chief complaint (CC) or presenting problem and history of present illness reported by the patient. It may include symptoms, conditions, previous diagnoses or other statements that describes why the patient is presenting. Helpful information also includes, onset, location, duration, characterization, alleviating and aggravating factors and severity of the CC. Relevant history (medical, surgical, family, social, medications, etc.) of the patient should also be discussed. A review of systems (inventory of body systems, i.e., questions arranged by organ system, designed to uncover dysfunction and disease) should be included.
>
> Objective. This section documents the objective data from the patient visit. This includes: vital signs; physical exam findings; laboratory, imaging, or other diagnostic data; and review of records by other clinicians.
>
> Assessment. This section documents the synthesis of "subjective" and "objective" evidence to arrive at a diagnosis. A differential diagnosis may list different possible diagnoses, from most to least likely, and include the practitioner's rationale.
>
> Plan. This section includes the plan for how the doctor will treat the patient's illness after taking into account all subjective and objective information.

"Strattera®" is a brand name for atomoxetine, which is a cognition-enhancing medication used to treat ADHD. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"SNRI" and "SSNRI" means selective serotonin and norepinephrine reuptake inhibitors, which are a class of medications that are effective in treating depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain. SNRIs work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression. SNRIs block the reabsorption (reuptake) of the neurotransmitters serotonin and norepinephrine in the brain. They are sold in several formulations, including desvenlafaxine (Pristiq®), duloxetine (Cymbalta®), levomilnacipran (Fetzima®), and venlafaxine (Effexor XR®). They are dangerous drug as defined in 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."

"Suboxone®" is a brand name for a formulation of buprenorphine that contains naloxone and a drug used to treat opiate addiction. Buprenorphine is an opioid medication that is similar to other opioids such as morphine, codeine, and heroin, however, it produces less euphoric effects and therefore may be easier to stop taking. Naloxone blocks the effects of opioids such as morphine, codeine, and heroin.

"Vyvanse®" see Lisdexamfetamine.

"Trazodone" is an antidepressant medication. It is used to treat major depressive disorder, anxiety disorders, and in addition to other treatment, alcohol dependence. It is a dangerous drug as defined in Business and Professions code section 4022.

"Xanax®" see alprazolam.

"Zoloft®" is the brand name for sertraline, which is a drug used to treat depression, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), social anxiety disorder, and panic disorder. It is a Selective Serotonin Reuptake Inhibitor (SSRI). 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.

FACTUAL ALLEGATIONS

Interview

12. On or about March 30, 2021, an investigator and medical consultant interviewed Respondent ("Interview") on behalf of the Board regarding the patients in this matter. During the Interview, Respondent stated that he worked at a clinic ("Clinic") staffed by other health care providers, including a psychologist who would provide therapy to patients and where he provided medical care (i.e., medication management with prescriptions drugs) to the patients. He stated that he would evaluate them before prescribing to them. During the Interview, Respondent also made several statements that evinced a lack of knowledge, including:

A. He had not applied for access to the CURES program as required by law.[1]

B. He could not remember the psychiatric diagnostic criteria for anxiety.

[1] At the Interview, Respondent blamed his secretary for failing to apply for the CURES program and alleged that he knew about the program's requirements.

C. He stated that he had looked at the Diagnostic and Statistical Manual of Mental Disorders, 5th Addition ("DSM-V") the day before the interview and knew Axis 1, 2, 3, 4, and 5 and "what each axis does." However, the DSM-V no longer uses a five axis (multiaxial) system to describe patients.

D. He could not adequately outline the components of a mental status examination of a patient.

Patient A[2]

13. The Board received a complaint from Patient A alleging that Respondent had excessively prescribed drugs to him, including Klonopin® and Xanax®, which he alleged caused negative effects on his personal relationships. He wrote that his last visit with Respondent was on or about March 18, 2017. Patient A was referred to Respondent by a psychologist at the clinic where Respondent worked for an evaluation for medication treatment of his anxiety.

14. A CURES report for the period from on or about July 9, 2015 through on or about July 9, 2018 revealed that Patient A filled prescriptions by Respondent from May 9, 2016 through January 30, 2017 and then after an interregnum from November 27, 2017 through January 29, 2018.

15. On or about April 24, 2016, Patient A, an 18-year-old man was seen by a psychologist at the Clinic. At that time, the patient had a history of taking Xanax® and complained of anxiety and difficulty sleeping. The psychologist referred the patient for a medication management.

16. On or about May 9, 2016, Respondent saw Patient A for the first time. In a four-page initial evaluation preprinted form, Respondent's notes were very minimal, including, "transfer from Dr. H." under a section entitled, "Purpose of Evaluation," and "see Dr. K's w/u" under "History of Present Illness." The history of present illness, current symptoms, past social, psychiatric, substance abuse history, family psychiatric history, and mental status exam are all blank. Under "diagnosis," Respondent wrote, "GAD" [generalized anxiety disorder], and the section under "treatment plan and medications," was blank. Patient A was taking very high doses

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

of controlled substances, including a maximum dosage of Adderall, 60 mg per day. However, Respondent failed to document Patient A's history of ADHD and anxiety symptoms, his past medication history, or previous medication trials. He also failed to document whether Patient A had tried SSRIs as an alternative to benzodiazepines for anxiety.

17. Thereafter, Respondent continued to see Patient A through 2017. However, Respondent's notes almost invariably consist of a current symptom checklist and a list of medications.[3] The rest of the notes, including mental status, assessment, and plan, are generally blank or lacking in information.

18. On or about May 10, 2016, Dr. K. saw Patient A and listed his medication as gabapentin, Abilify® and trazodone. He also documented that the patient saw Dr. "H." for two years, was on Klonopin® 4 mg "didn't work[4] but Xanax does (2 mg bid works) [and] wants...Adderall but doesn't want to take possible alternatives like Strattera." The record also indicated that the patient smokes marijuana 8 times a day.[5]

19. On or about May 18, 2016, Respondent documented that Patient A was suffering from poor sleep, anxiety and panic attacks. He prescribed alprazolam, clonazepam and Adderall® to Patient A (filled on or about May 26, 2016). However, Respondent failed to document why he prescribed two benzodiazepines simultaneously to the patient; each at high dosages.[6]

20. On or about June 5, 2016, Respondent saw Patient A and documented that the patient had "tons of anxiety" and was on Adderall® 20 mg tid, Xanax® 4 mg per day, and clonazepam 8 mg per day. He also planned to "Raise Xanax"... "another med for ADHD" "or "find another

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[3] The form requests that the patient "please check any of the following you are experiencing" and lists items; it also asks the patient to "list any medications you are taking."

[4] However, Respondent prescribed this drug to the patient and did not explain why he prescribed the drug to the patient.

[5] The possibility of a cannabis use disorder and its impact on treatment are not addressed by Respondent in his records.

[6] According to a summary of treatment, dated November 19, 2018, provided by Respondent, Patient A informed Respondent that he had lost his prescriptions and Respondent wrote him a new prescription for Xanax®, Klonopin®, trazodone, and Adderall®. However, Respondent's medical records for Patient A fail to mention any lost prescriptions. Moreover, the maximum dose of Adderall® is 60 mg/day, and Patient A received a 30 day supply of this from another provider on or about May 7, 2016 and another 30 day supply from Respondent on or about May 26, 2016, suggesting he was using 90 mg per day.

one that's better than Xanax." Although there are non-controlled substance alternative medications to treat anxiety including SSRIs, SNRIs, atypical antipsychotics, and anti-seizure drugs, Respondent did not explore these options with the patient. In addition, high dose prescriptions for Adderall® can worsen anxiety symptoms in a patient.

21. On or about June 8, 2016, Patient A filled a prescription for alprazolam 2 mg (# 60), after his previous refill for alprazolam on or about May 26, 2016.

22. On or about June 22, 2016, Patient A filled Respondent's prescriptions for clonazepam 2 mg # 120 and amphetamine salt combo (Adderall®) 20 mg (# 90). Patient A also exhibited symptoms of psychosis.

23. On or about June 27, 2016, Patient A filled Respondent's prescription for clonazepam 2 mg, # 60. This was approximately five days after filling a 30 day supply of the drug at 8 mg per day.

24. On or about August 3, 2016, Respondent saw Patient A and increased his prescription dose of alprazolam to 2 mg (# 90), and in addition his prescription for clonazepam was 2 mg (#90). Respondent's note for this visit consisted of only a list of three of the patient's medications, and three items on the checklist.

25. On or about June 29, 2016 through August 21, 2016, Patient A filled prescriptions for controlled substances from four other prescribers including, carisoprodol (Soma®), codeine (opioid), hydrocodone (opioid), Vyvanse 30 mg (a stimulant), lorazepam 1 mg # 60 (benzodiazepine), and zolpidem (a sedative). Opioids and benzodiazepines are dangerous when combined as they create is a higher risk for overdose.

26. On or about August 31, 2016, Patient A filled a prescriptions for clonazepam, alprazolam, and Adderall®. However, clonazepam was also refilled on or about October 24, 2016; December 12, 2016; and January 23, 2017. Respondent's chart notes dated August 31, 2016; September 21, 2016; October 17, 2016 and December 12, 2016 contained very limited information mostly from the preprinted checklists.

27. On or about January 30, 2017, Respondent saw Patient A and his progress note for that visit contains a comment written on or about February 1, 2017 stating that, "on next visit he

should taper Xanax and Klonopin" without any rationale. The prescriptions include Adderall® (same dose), Xanax® (dose increased to 2 mg 5 times per day), and Klonopin® (increased to 2 mg 3 times per day), without any further explanation. Patient A refilled his prescription for alprazolam on or about each of the following days, October 16, 2016, October 26, 2016, December 12, 2016, and January 23, 2017; and refilled his prescription for Adderall® on or about September 28, 2016, and January 30, 2017.

28. Thereafter, an interruption in Respondent's treatment of Patient A occurred until in or around November 2017. During this period, Patient A appeared to have received medication treatment from different providers who prescribed the following opioid partial agonist (used in the treatment of opioid use disorder) drugs to the patient on or about the following dates: Suboxone®, June 8, 2017; buprenorphine, July 31, 2017; buprenorphine, October 12, 2017; buprenorphine, October 16, 2017.

29. On or about November 27, 2017, Respondent saw Patient A again, but failed to document the patient's interruption in treatment with Respondent. Respondent failed to adequately document why Patient A was absent for approximately 10 months and what treatment he received during that time, if any. Instead, his standard form progress note checklist merely indicated that nine items on the possible symptom list were checked and the list of the patient's current medications included: Adderall® 20 mg (3 times per day), Klonopin® 2 mg (3 times per day), and Xanax® 2 mg (5 times per day). Respondent discontinued the prescription for Klonopin®, but failed to include his rationale for such cessation. He also reduced the patient's prescription for Xanax® to twice per day, without an adequate explanation. Respondent prescribed Ambien® to the patient, by "calling" it in with a note dated either November 27 or 29, 2017. A note indicated that Restoril® "worked before," but Trazadone® "does not work."

30. From on or about November 27, 2017 through January 29, 2018, Respondent prescribed Adderall® 20 mg (#60 once, and # 90 twice); alprazolam (1 mg # 120 twice, and 2 mg #60 once), and zolpidem 10 mg (# 30 three times).

31. On or about December 5, 2017, Patient A failed to show for his therapy appointment.[7]

[7] A September 29, 2016 psychologist note stated Patient A was not interested in therapy.

32. Progress notes dated December 18, 2017 and January 29, 2018 indicated that the patient was prescribed Xanax®, Adderall ®, and Ambien ®. However, no rationale for any modifications to the patient's prescription was documented.

33. On or about May 2, 2018, Respondent saw Patient A for the final time with complaints of depression, anxiety, racing heart, shaky hands, worrying and an inability to relax. Respondent prescribed the following drugs to Patient A at that visit: Xanax® (4 mg per day), Zoloft® (100 mg per day), Strattera® (50 mg per day), and Ambien® 10 mg.

34. On or about October 3, 2018, Patient A came to the Clinic, demanded to see Respondent and became upset.

Patient B

35. A CURES report for the period from on or about May 29, 2016 through on or about May 29, 2019, revealed that Patient B filled prescriptions by Respondent on a monthly basis (approximately) for Adderall® and clonazepam.

36. On or about January 18, 2016, Respondent first saw Patient B, a 33-year-old man. Respondent's records for Patient B were also written on a preprinted form with a check-the-box list of symptoms. For this visit, the boxes for anxiety and poor attention span were checked and the patient's current medications included Adderall®, clonazepam and sertraline (Zoloft®). Respondent's plan at this visit included: "psychotherapy / medication." Respondent continued to see Patient B on a monthly basis (approximately) through on or about August 13, 2020 (although there is an interruption in visits from on or about March 17, 2020, until on or about July 17, 2020). Respondent's records for Patient B are very sparse and generally consist of checklists, short sentences such as, "effectively dealing with anxiety," and a plan for "psychotherapy / medication." Nevertheless, Respondent continued to prescribe dangerous drugs to the patient, but failed to adequately document his rationale for his prescribing.

37. On or about June 1, 2020, Respondent prescribed KlonoPin®, but there is no corresponding office visit for this prescription.

38. During the Interview, Respondent stated that Patient B's presentation at his visit on or about April 9, 2018 included symptoms of indecisiveness, lack of interest, and depression and

anxiety. However, his form did not show any mark for depression or anxiety. When asked by the Board's medical consultant why depression was not marked as a symptom, Respondent stated that he did not know why "it's not there." Although Respondent allegedly could remember that the patient had depression, despite the lack of documentation of that symptom in the patient's chart, at that same visit, when asked about what he prescribed to the patient at that visit, Respondent stated that he would have to refer to the patient's previous visit to answer the question.

39. During the Interview, in response to an inquiry into the meaning of Respondent's note stating, "appropriate development" under the heading, "Assessment," in his progress noted dated February 6, 2019, Respondent after reflecting on the phrase stated, it was "'justification for continued treatment' [reading from what is printed on the form], appropriate development - it means that he – in his life, he was developing," When asked to elaborate further, Respondent stated, "he ended up – getting married – he ended up having a – getting jobs." However, these details are not in Respondent's medical records for this visit. Respondent also stated that he did not check the patient's records in CURES because he did not have access to CURES.

Patient C

40. A CURES report for the period from on or about May 29, 2016 through on or about May 29, 2019 revealed that Patient C filled prescriptions by Respondent on a monthly basis (approximately) for medications, including zolpidem and alprazolam.

41. On or about April 17, 2018, Respondent saw Patient C, an 89-year-old woman who he diagnosed with mood disorder and depression. During the Interview, Respondent stated that Patient C's depression was based upon her disagreement with her daughter who was living with her and they were arguing with each other, and that she felt that her daughter was "trying to control her." However, these details were not present in his medical record for the patient. Respondent also stated that he had been regularly treating Patient C for anxiety with Xanax®.

Patient D

42. A CURES report for the period from on or about May 29, 2016 through on or about May 29, 2019 revealed that Respondent prescribed medications to Patient D, including on or

about August 7, 2016 for methylphenidate 20 mg, # 180 (120 mg/day),[8] lorazepam 1 mg, # 90 and zolpidem 5 mg, # 30.

43. On or about August 7, 2017, Respondent first saw Patient D, a 56-year-old man. Respondent documented that the patient "wants to d/c Ritalin." Respondent also diagnosed the patient with ADD and prescribed Adderall® to the patient, without documenting any details about why the patient wanted to stop Ritalin, why he desired Adderall®, or what evidence supported Respondent's diagnosis.

44. On or about February 12, 2018, Respondent saw Patient D and diagnosed him with ADHD; however, he failed again to list any symptoms of the patient.

45. Thereafter, Respondent continued to treat Patient D and prescribed controlled substances to him, including through in or around May 2019.

FIRST CAUSE FOR DISCIPLINE

(Failure to Apply for Access to and Monitor under CURES)

46. Respondent is subject to disciplinary action under sections 11165.1 and 11165.4 of the Health and Safety Code in that he failed to apply for electronic access to information in the CURES system by the required deadline and failed to utilize the system to periodically monitor his patients before and while prescribing controlled substances to them. The circumstances are as follows:

47. During the Interview, Respondent admitted that he never applied for access to the CURES system and therefore he did not access the CURES database during the time he treated Patients A, B, C and D. Furthermore, Respondent was not aware that he was legally required to apply for CURES access by October 2, 2018 and/or negligently failed to comply with his prescribing requirements under the CURES system as set forth below.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. 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 patients. The

[8] The normal maximum dosage of methylphenidate is 60 mg per day.

circumstances are as follows:

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

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

A. During all relevant time periods herein, including when Respondent treated Patients A, B, C and D, including through March 30, 2021 (the date of his Interview), Respondent failed to apply for access to CURES and failed to monitor CURES while he was prescribing to the patients.

B. During all relevant time periods herein, Respondent failed to adequately document an adequate medical history for his patients. His documentation for his patients conveys very little information about his patients and fails to contain an adequate amount of information normally found in the records of a psychiatrist.[9]

C. During all relevant time periods herein, Respondent failed to adequately document relevant medical information related to medications prescribed for each of Patients A, B, C and D, including his rational for any medication changes, high dosages or combinations of drugs (including two benzodiazepines at the same time). He failed to adequately document the symptoms of each patient, including their emergence and state of improvement or worsening. His records for these patients only included a checklist of symptoms and a list of medications.

D. During all relevant time periods herein, Respondent prescribed stimulant medications to patients without documenting his monitoring of the patient's heart rate, blood pressure or weight. Stimulant medications such as Adderall® can raise a patient's blood

[9] Generally speaking, a psychiatric history should include the patient's presenting symptoms (or chief complaint), history of present illness, past psychiatric history, including a history of past medication trials, substance abuse history, medical history, family history, mental status examination, diagnostic formulation, and treatment plan. With respect to any prescribed medication, its dosage, duration, efficacy and side effects should be documented; and if unusual combinations of medications are prescribed (e.g., medications in the same class), it is important to document the rationale for this combination. Further, if the patient is taking an unusually high dosage of a medication, its rationale should be documented. Finally, if the patient is taking controlled substances, the patient's history of substance abuse should be documented.

pressure, pulse rate, and cause weight loss. Thus, a patient's blood pressure, pulse, and weight before the start of treatment and during the treatment must be monitored for potential hypertension or tachycardia (which could put them at risk of adverse events). Respondent prescribed amphetamine salts to Patients A and B, and methylphenidate to Patient D; and failed to adequately document his monitoring of their heart rate, blood pressure or weight.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

51. 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:

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

53. During all relevant time periods herein, including during his Interview, Respondent failed to possess adequate knowledge about the components of a mental status examination, the criteria for generalized anxiety disorder and/or mistakenly applied the five axis multiaxial system to the DSM-5. Knowledge of the components of the mental status exam is a fundamental part of practicing psychiatry. Further, knowledge of the basic diagnostic criteria for the psychiatric conditions that a practitioner most frequently encounters (such as anxiety) is necessary to practice psychiatry. During his Interview, Respondent could not state (A) the components of a mental status exam, or (B) the criteria for generalized anxiety disorder. He also conflated the use of the five axis multiaxial system with the DSM-5 despite the fact that it was discarded when the DSM-5 was introduced.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

54. 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 his patient. The circumstances are as follows:

55. The allegations of the First, Second and Third Causes for Discipline, inclusive, are

incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination and Excessive Prescribing)

56. 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:

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

58. Respondent failed to provide adequate rationales for the dangerous drugs, including controlled substances he was prescribing to his patients, including high doses of alprazolam (10 mg per day) and clonazepam (6 mg per day) to Patient A.

59. In addition, Respondent prescribed drugs to his patients, without a corresponding chart note of a patient encounter documented in his records. In or around 2017, Respondent prescribed zolpidem to Patient C on multiple occasions, but failed to adequately document his rationale for the medication.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

60. 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:

61. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline, inclusive, are incorporated herein by reference 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 G 15977, issued to Gregory L. Gorski, M.D.;

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

3. Ordering Gregory L. Gorski, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. If disciplined and applicable, ordering Gregory L. Gorski, M.D., to disclose his discipline to patients as required by section 2228.1 of the Code; and

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

DATED: MAY 11 2021

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

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