ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012

Attorneys for Complainant

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

In the Matter of the Accusation Against: **RONALD GODWIN PERSAUD, M.D.** **4505 Las Virgenes Road, Suite 204** **Calabasas, CA 91302** **Physician's and Surgeon's Certificate No. C 52276,** Respondent.	Case No. 800-2018-049765 **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 March 30, 2006, the Board issued Physician's and Surgeon's Certificate No. C 52276 to Ronald Godwin Persaud, 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 November 30, 2023, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

///

///

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:

". . .

"(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.

". . . ."

6. 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."

7. 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."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

9. **Adderall**, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system (CNS) stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder (ADHD) and narcolepsy. According to the Drug Enforcement Administration (DEA), amphetamines, such as Adderall, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2017), at p. 50.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

10. **Clonazepam**, a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When

properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. The maximum daily dose of clonazepam is generally not to exceed 4 mg per day. Concomitant use of clonazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as clonazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

11. **Gabapentin** is a prescription painkiller belonging to its own drug class, Gabapentinoids. It is primarily used as an anti-epileptic drug, and also used as an anticonvulsant and nerve pain medication.

12. **Lisdexamfetamine**, commonly known by the trade name Vyvanse, is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Lisdexamfetamine is used to treat ADHD. The DEA has identified amphetamines, such as lisdexamfetamine, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

13. **Lorazepam**, also known by the trade name Ativan, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures.

14. **Methylphenidate**, commonly known by the trade name Ritalin, is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Methylphenidate is used to treat ADHD and narcolepsy. The DEA has identified amphetamines, such as methylphenidate, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

15. **Paroxetine**, an antidepressant, belongs to a group of drugs known as an SSRI (selective serotonin reuptake inhibitor). It's commonly used to treat depression and sometimes for obsessive compulsive disorder (OCD), panic attacks, anxiety or post-traumatic stress disorder (PTSD).

16. **Soma**, a trade name for carisoprodol tablets, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It can be habit forming and its side effects may impair thinking or reactions; it can increase dizziness and drowsiness.

17. **Tramadol** is a synthetic opioid used to treat moderate to severe pain, especially post-surgery. It has a high risk for addiction and dependence.

18. **Trazodone** is an antidepressant used to treat major depressive disorder. It belongs to a group of drugs called serotonin receptor antagonists and reuptake inhibitors (SARIs).

19. **Venlafaxine**, an antidepressant, belongs to a group of drugs called SSNRIs. Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression.

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

21. **Zolpidem**, known by the trade name Ambien, is a Schedule IV controlled substance, and a sedative primarily used to treat insomnia. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

///

[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

PATIENT L

23. Respondent began treatment with Patient L, a then 25-year-old male, on or about September 6, 2018. The patient reported a history of anxiety, panic attacks, insomnia, and ADHD. Patient L stated that his ADHD symptoms were being adequately treated by Adderall. He denied substance use disorder. Patient L had a spinal cord disorder and was paralyzed from the waist down. Following a comprehensive mental status examination, Respondent diagnosed Patient L with panic disorder and ADHD. Respondent continued the patient on Adderall (60 mg daily), and started alprazolam (1 mg daily), zolpidem (10 mg nightly), and paroxetine (20 mg daily). The dosage of Adderall prescribed to Patient L was above the maximum recommended dosage, yet Respondent did not document the reason for this high dosage, nor obtain vital signs of the patient. Additionally, Respondent did not provide the justification or document informed consent regarding the combination of scheduled medications prescribed, nor did he check CURES[2] prior to prescribing these medications. Respondent also failed to provide an adequate justification for the long-term use of zolpidem, a medication indicated for short-term use.

24. On or about September 13, 2018, Respondent tripled the dosage of alprazolam (3 mg daily) and provided an early refill without an office visit. Further, Respondent did not document this increase in dosage (other than the medication log), provide a reason for the increased dosage, nor review CURES prior to issuing this prescription. On or about October 3, 2018, Respondent again increased the dosage of alprazolam (3.5 mg), despite Patient L reporting that he was taking 4 mg daily, more than the prescribed dosage. Further, Respondent did not document a discussion regarding any concerns of substance use disorder or diversion. Respondent continued regular prescriptions for Adderall and zolpidem, increased the dosage of paroxetine (30 mg daily), and started trazadone (100 mg nightly) and buspirone, an anti-anxiety medication (30 mg daily). Respondent checked CURES the day prior to this visit. On or about November 1, 2018, Respondent again increased the dosage of alprazolam (4 mg daily).

[2] The Controlled Substance Utilization Review and Evaluation System (CURES) is a platform that tracks all Schedule II – IV controlled substances dispensed to patients in California.

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

(a) Respondent tripled the dosage of alprazolam without an office visit and failed to adequately document this increased dosage, provide a justification, or review CURES prior to prescribing this medication.

PATIENT B

26. Respondent began treating Patient B, a then 24-year-old female, on or about March 6, 2018. The patient reported a history of numerous psychiatric symptoms, including anxiety, ADHD, and psychosis. Following a comprehensive mental status examination, Respondent diagnosed Patient B with schizophrenia and ADHD. Respondent continued her prior prescriptions for lurasidone, an antipsychotic (60 mg daily); aripiprazole, an antipsychotic (2 mg daily);[3] lamotrigine (anticonvulsant); lisdexamfetamine (20 mg daily); clonazepam (1 mg daily); vilazodone (SSRI antidepressant); and trazodone (100 mg nightly).

27. On or about May 29, 2018, Patient B reported anxiety and command auditory hallucinations of self-harm. However, Respondent did not conduct a suicide risk assessment, document how to treat the patient's psychosis, or document the risks associated with the use of stimulants by a patient with psychosis. Respondent discontinued lisdexamfetamine and started Adderall (10 mg daily).

28. On or about July 3, 2018, Patient B reported continued auditory hallucinations. Respondent discontinued trazodone as it was reportedly contributing to the patient's nightmares. The following month, Patient B again reported auditory hallucinations, but her medications were unchanged. On or about November 5, 2018, Respondent discontinued clonazepam and started alprazolam (1.5 mg daily). On this date, Respondent also checked CURES for the first time, and would check CURES on six additional occasions through approximately June 2020. Yet on none of these occasion did Respondent document an analysis of his CURES review or note that Patient B was regularly prescribed opiates by other providers, including oxycodone and hydrocodone.

[3] The general starting daily dosage of aripiprazole to treat schizophrenia is 10 mg, yet Respondent only prescribed 2 mg; Respondent prescribed lurasidone at 60 mg even though the maximum dosage is 160 mg, then decreased it further to 40 mg in April 2019.

29. Between approximately May 2019 and September 2019, Respondent's documentation indicated that Patient B did not have any prescription refills, but pharmacy records reflect that numerous prescriptions were issued by Respondent during this time, including Adderall. On or about November 18, 2019, Adderall was discontinued, but it was not documented. On or about December 5, 2019, Patient B reported having a seizure and increased anxiety from Adderall, and Respondent switched her back to lisdexamfetamine. Several days later, Respondent issued a prescription for clonazepam without an office visit and ceased alprazolam, however, it is only noted in the medication logs and not the medical notes.

30. On or about January 3, 2020, Patient B reported worsening anxiety and panic. Respondent increased clonazepam (3 mg daily) and lamotrigine (150 mg daily). On or about March 3, 2020, Patient B was switched from lisdexamfetamine to methylphenidate (20 mg daily) without an office visit or documenting informed consent. Soon after, the patient reported palpitations associated with methylphenidate, and Respondent lowered the dosage to 10 mg daily.

31. On or about June 8, 2020, Patient B reported taking a higher dosage of methylphenidate than prescribed, and again hearing command auditory hallucinations of self-harm. Respondent in turn increased the dosage of methylphenidate back to 20 mg daily, but again failed to conduct a suicide risk assessment or substance use disorder assessment.

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

(a) Respondent failed to adequately address the patient's command auditory hallucinations of self-harm on or about May 29, 2018; and

(b) Respondent failed to adequately address the patient's command auditory hallucinations of self-harm on or about June 8, 2020.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

PATIENT L

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

(a) Paragraphs 22 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to address the reason Adderall was prescribed above the maximum recommended daily dosage;

(c) Respondent failed to provide a clear justification and explanation of the risks associated with the concurrent use of Adderall, alprazolam, and zolpidem;

(d) Respondent failed to monitor CURES prior to prescribing controlled substances;

(e) Respondent failed to obtain vital signs when prescribing scheduled medications, including Adderall;

(f) Respondent prescribed zolpidem, a medication indicated for short-term insomnia use, for long-term use without clear justification; and

(g) Respondent failed to address concerns of diversion or substance use disorder following the patient's admission to taking more than the prescribed dosage of alprazolam.

PATIENT S

35. Respondent started treating Patient S, a then 42-year-old male, on or about August 26, 2016. The patient reported symptoms of depression and ADHD, and denied substance use disorder. Following a comprehensive mental status examination, Respondent diagnosed Patient S with persistent depressive disorder and ADHD. Respondent continued the patient's previously prescribed medications, including venlafaxine (150 mg daily), lisdexamfetamine (200 mg daily), trazodone (200 mg nightly), and gabapentin (3200 mg daily). Patient S came in for monthly appointments the remainder of 2016 and the treatment plan remained unchanged. On or about

November 29, 2016, Patient S began receiving regular prescriptions for tramadol from another prescriber.

36. On or about January 13, 2017, Patient S reported worsening symptoms of depression. Respondent switched him from lisdexamfetamine to Adderall (20 mg daily), while continuing the other regular prescriptions. Starting in approximately January 2017 through January 2018, Patient S received regular prescriptions for opioids from another provider, and at times, multiple providers. These medications included acetaminophen-codeine and hydrocodone. Patient S also started receiving regular prescriptions for Soma from another provider from approximately February 2017 through April 2018. On or about February 17, 2017, Patient S reported drowsiness from taking trazodone, which was then decreased.

37. On or about March 17, 2017, Respondent increased the dosage of Adderall (30 mg daily) and trazodone (150 mg nightly) following Patient S reporting poor focus and anxiety. On or about October 4, 2017, Patient S reported being in a car accident. On or about December 18, 2017, Respondent added lorazepam (1 mg daily) as the patient reported continuing depression and anxiety. On or about June 11, 2018, Respondent switched venlafaxine to desvenlafaxine, another antidepressant, but resumed venlafaxine the following month after Patient S reported having withdrawal symptoms from stopping venlafaxine.

38. On or about October 31, 2018, Respondent checked CURES for the first time, and would check CURES on six additional occasions through approximately May 2020. However, on none of these occasions did Respondent document an analysis of his CURES review or make notations of the multiple opioids being prescribed by other providers. On or about January 18, 2019, Respondent switched the patient from lorazepam to alprazolam (.75 mg daily) after Patient S reported lorazepam to be ineffective. Even though Respondent noted that lorazepam was discontinued on this date, he prescribed lorazepam on two additional occasions to the patient. On or about May 31, 2019, Patient S reported having cannabis in his urine.

39. Since starting treatment with Respondent on or about August 26, 2016, Patient S repeatedly complained of symptoms of ongoing depression and life stressors. However, Respondent did not alter his antidepressant medications until starting desvenlafaxine on or about

June 11, 2018, and the antidepressants were largely unchanged thereafter. Moreover, Respondent failed to document a suicide risk assessment following numerous reports of increasing depression, and prescribed benzodiazepines, which can worsen depression. Further, Respondent did not advise Patient S of the risks associated with the concurrent use of opiates and benzodiazepines at the time he prescribed benzodiazepines.

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

(a) Respondent failed to timely monitor CURES and, as a result, overlooked that the patient was being prescribed opiates and sedatives by other providers at the same time Respondent was prescribing controlled substances;

(b) Respondent prescribed lorazepam despite a recent car accident and complaints of drowsiness, and without monitoring CURES;

(c) Respondent noted that lorazepam was discontinued, yet issued two subsequent prescriptions without proper documentation;

(d) Respondent failed to document a consideration of substance use disorder when the patient admitted to marijuana use;

(e) Respondent failed to document an analysis of his CURES review or make notations of the multiple opioids being prescribed by other prescribers;

(f) Respondent failed to advise the patient of the risks associated with the concurrent use of opiates and benzodiazepines;

(g) Respondent failed to properly address the patient's symptoms of depression; and

(h) Respondent failed to document a suicide risk assessment despite repeated reports of depression and life stressors.

///

///

PATIENT B

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

(a) Paragraphs 26 through 32, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to timely monitor CURES and, as a result, missed that the patient was also being prescribed opiates by other providers at the same time Respondent was prescribing controlled substances;

(c) Respondent failed to document an analysis of his CURES review or make notations of the multiple opiates being prescribed by other prescribers;

(d) Respondent failed to adequately document prescriptions of controlled substances between May 2019 through September 2019;

(e) Respondent prescribed clonazepam on or about December 8, 2019, without an office visit;

(f) Respondent switched Patient B from lisdexamfetamine to methylphenidate on or about March 3, 2020, without an office visit or documenting informed consent;

(g) Respondent failed to conduct a substance use disorder assessment following the patient's admission that she was taking more than the prescribed amount of methylphenidate; and

(h) Respondent failed to increase and/or change the patient's antipsychotic medications despite continuous psychotic symptoms.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

42. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to patients L, S, and B, as determined by the standard of the

community of physicians, as more particularly alleged in paragraphs 22 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

43. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of patients L, S, and B, as more particularly alleged in paragraphs 22 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 52276, issued to Respondent Ronald Godwin Persaud, M.D.;

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

3. Ordering Respondent Ronald Godwin Persaud, 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: OCT 21 2021

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

LA2021603701
83070310.docx