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

In the Matter of the Accusation Against: **SCOTT DRAGOSH ISPIRESCU, M.D.** **PO Box 7260** **Laguna Niguel, CA 92607-7260** **Physician's and Surgeon's Certificate No. A 63583,** Respondent.	Case No. 800-2019-052107 **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 3, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63583 to Scott Dragosh Ispirescu, 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 August 31, 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 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:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (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.
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> (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.
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> (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:
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> (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.
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> (b) Gross negligence.
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> (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 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.

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

COST RECOVERY

8. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 63583 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A,[1] and Patient B, as more particularly alleged hereinafter:

Patient A

10. On or about October 18, 2018, Patient A first presented to Respondent. At that time, Patient A was a forty-one (41) year-old female, who indicated that her son had passed away and she felt unable to return to work. She had received ketamine[2] infusions, which had been helpful, but were too sedating. Patient A also reported insomnia, poor concentration, and hopelessness.

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[1] References to "Patient A" and "Patient B" are used to protect patient privacy.

[2] Ketamine is a medication primarily used for induction and maintenance of anesthesia.

Patient A stated that she was being prescribed Zoloft[3] 50 q.d.[4], Pristiq[5] 80 Qday, Xanax[6] 0.5 q.d., Adderall[7] 20 TID.[8] Respondent noted Patient A's allergies, family history of mental illness, and her social history. The mental status exam noted appropriate appearance, behavior, speech, affect, thought content, thought process, cognition, insight, and judgment, but a depressed and anxious mood. Patient A was diagnosed with MDD[9] and ADHD.[10] The treatment plan included restarting Pristiq 50 q.d., Adderall 20 TID, and starting Remeron[11] 15 Qhs.[12] Respondent failed to document and/or assess Patient A's substance use history and/or disorder. Respondent also

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[3] Zoloft is a Selective Serotonin Reuptake Inhibitor (SSRI), which can be used to treat depression, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), social anxiety disorder, and panic disorder.

[4] Quaque die (q.d.) stands for once a day.

[5] Pristiq (desvenlafaxine) is an antidepressant, which can be used to treat depression.

[6] 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 Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[7] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system 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 and narcolepsy. According to the 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 (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

[8] Ter in die (TID) stands for three times a day.

[9] Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Major Depressive Disorder (MDD), also called clinical depression, affects how a person feels, thinks, and behaves, and can lead to a variety of emotional and physical problems.

[10] Attention Deficit Hyperactivity Disorder (ADHD) is a chronic condition including attention difficulty, hyperactivity, and impulsiveness.

[11] Remeron (mirtazaphine) is an antidepressant, which can be used to treat depression.

[12] Quaque hora somni (Qhs) refers to every night at bedtime.

failed to obtain a CURES[13] report, despite prescribing controlled substances and despite Patient A's history of using controlled substances. Respondent failed to document and/or assess Patient A's suicide risk, despite Patient A's significant history of depression and prior treatment with ketamine.

11. On or about November 1, 2018, Patient A returned to Respondent, reporting that her medications were helpful, but she was having continued insomnia. The mental status exam was within normal limits with appropriate speech, behavior, thought process, fund of knowledge, mood, thought content, judgment, memory, attention, and concentration. Respondent again failed to check Patient A's CURES report(s).

12. On or about December 7, 2018, Patient A returned to Respondent, reporting that Remeron was causing edema and daytime sedation. The mental status exam was within normal limits. The treatment plan included discontinuing Remeron and starting trazadone[14] 12.5 Qhs. Respondent failed to check Patient A's CURES report(s).

13. On or about January 10, 2019, Patient A returned to Respondent, reporting that the edema had subsided when she stopped Remeron, but that she experienced worsening depression with lower energy. Patient A reported that her insomnia had improved. The mental status exam was within normal limits. The treatment plan included starting Wellbutrin[15] XL 150 q.d. Respondent failed to check Patient A's CURES report(s).

14. On or about March 20, 2019, Patient A presented to Respondent, reporting that Wellbutrin was no longer effective. The mental status exam was within normal limits. The treatment plan included increasing Wellbutrin XL to 300 q.d. and cross-tapering Cymbalta[16] and

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[13] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

[14] Trazadone in an antidepressant and a sedative, which can be used to treat depression.

[15] Wellbutrin (bupropion) is an antidepressant, which can be used to treat depression.

[16] Cymbalta (duloxetine) is an antidepressant and nerve pain medication, which can be used to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain.

Pristiq over 1 week, with Cymbalta becoming 60 q.d.

15. On or about April 18, 2019, Patient A returned to Respondent, reporting that she prefers Pristiq over Cymbalta and that her insomnia had improved. The mental status exam was within normal limits. The treatment plan included discontinuing Cymbalta, discontinuing trazadone, restarting Pristiq 50 q.d., and changing Wellbutrin XL to Aplenzin[17] 348 q.d.

16. On or about May 21, 2019, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits and noted appropriate speech, thought process, thought content, judgment, memory, attention, concentration, behavior, fund of knowledge, and mood. The treatment plan was unchanged and included Adderall 20 TID, Pristiq 50 q.d., and Aplenzin 348 q.d.

17. On or about July 25, 2019, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

18. On or about August 22, 2019, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The only diagnosis listed was MDD. The treatment plan was unchanged.

19. On or about September 17, 2019, Patient A returned to Respondent, reporting hot flashes. Respondent discussed with Patient A going to the OB-GYN, hormones, and niacin.[18] The mental status exam was within normal limits. The treatment plan was unchanged.

20. On or about October 24, 2019, Patient A returned to Respondent, reporting insomnia. The mental status exam was within normal limits. The treatment plan included starting niacin, vitamin C, and magnesium L-threonate.[19]

21. On or about November 25, 2019, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits and noted appropriate speech,

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[17] Aplenzin is an antidepressant, which can be used to treat depression and help people quit smoking.

[18] Niacin (Vitamin B3) is a chemical compound, which can be used to treat high cholesterol triglyceride levels as well as niacin deficiency.

[19] Magnesium L-Threonate is among the most absorbable forms of magnesium pills.

thought process, thought content, judgment, memory, attention, concentration, behavior, fund of knowledge, and mood. The treatment plan was unchanged and included Adderall 20 TID, Pristiq 50 q.d., and Aplenzin 348 q.d., as well as niacin, and magnesium.

22. On or about January 15, 2020, Patient A returned to Respondent, reporting no complaints. The treatment plan was unchanged.

23. On or about March 2, 2020, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The diagnosis listed were MDD and ADHD. The treatment plan was unchanged.

24. On or about March 31, 2020, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

25. On or about April 21, 2020, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

26. On or about May 19, 2020, Patient A returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

27. On or about June 15, 2020, Patient A returned to Respondent, reporting diminished energy and insomnia. The mental status exam was within normal limits. The treatment plan was unchanged and included Adderall 20 TID, Pristiq 50 q.d., and Aplenzin 348.

28. During Respondent's care and treatment of Patient A, from on or about October 18, 2018 through June 15, 2020, Respondent failed to document, check, or obtain from the primary care provider, vital signs or physical examinations.

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Patient B

29. On or about August 10, 2016, Patient B first presented to Respondent. At that time, Patient B was a sixty (60) year-old female. Patient B had completed a rehabilitation program for alcohol use disorder and was fifty-one (51) days sober. Patient B also had a history of 5 medical hospitalizations for kidney infections in the past year, a blood clot, hepatitis C, and high blood pressure. Patient B was prescribed Celexa[20] 40 q.d., Seroquel[21] 100 Qhs, doxepin[22] 20 Qhs, Ambien[23] 10 Qhs, clonidine[24] 0.1 q.d., as well as warfarin 4 q.d, and amlodipine 10 q.d. The treatment plan was to continue Celexa 40 q.d. and Ambien 10 Qhs. Respondent failed to adequately obtain and/or failed to document having adequately obtained Patient B's substance use history. Respondent failed to obtain a CURES report and/or pharmacy records despite prescribing controlled substances to Patient B, Patient B's history of substance use disorder, and her history of using controlled substances. Respondent failed to assess and/or failed to document having assessed Patient B's suicide risk, despite Patient B's significant history of mood disorder and a substance use disorder.

30. On or about September 6, 2016, Patient B returned to Respondent, reporting low energy. The mental status exam was within normal limits with appropriate speech, thought process, thought content, and judgment. Patient B's diagnoses included substance-induced mood disorder, as well as alcohol dependence in remission. The treatment plan included Celexa 40 q.d., Ambien 10 Qhs, as well as a recommendation to get a sleep study.

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[20] Celexa (citalopram) is a Selective Serotonin Reuptake Inhibitor (SSRI), which can be used to treat depression.

[21] Seroquel (quetiapine) is an antipsychotic, which can be used to treat schizophrenia, bipolar disorder, and depression.

[22] Doxepin is an antidepressant and nerve pain medication, which can be used to treat depression, anxiety, and sleep disorders.

[23] Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, 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 short-term treatment of insomnia characterized by difficulties with sleep initiation.

[24] Clonidine is a sedative and antihypertensive drug, which can be used to treat high blood pressure.

31. On or about October 3, 2016, Patient B returned to Respondent, reporting that at night, her husband noticed her snoring and then stopping snoring to breathe, which may be associated with some recent weight gain. The mental status exam was within normal limits. The treatment plan was unchanged.

32. On or about October 21, 2016, Patient B returned to Respondent, reporting that she is now working, denied complaints, but mentioned suffering from insomnia, when she does not use Ambien. The mental status exam was within normal limits. The treatment plan was unchanged.

33. On or about November 14, 2016, Patient B returned to Respondent, reporting frequent awakenings at night. Patient B has completed a sleep study. The mental status exam was within normal limits. The treatment plan was unchanged.

34. On or about December 12, 2016, Patient B returned to Respondent, reporting no complaints. Patient B indicated that she had been sober for six (6) months. The mental status exam was within normal limits. The diagnoses now included obstructive sleep apnea. Respondent discussed treatment options for sleep apnea, though Respondent did not include in the note that Ambien can worsen sleep apnea.[25] The treatment plan was unchanged.

35. On or about January 10, 2017, Patient B returned to Respondent, reporting no psychiatric complaints. The mental status exam was within normal limits. The treatment plan was unchanged and noted that Patient B will attempt to quit smoking.

36. On or about February 9, 2017, Patient B returned to Respondent, reporting that she had gone to the hospital due to low blood pressure. Patient B also reported some continued insomnia. The mental status exam was within normal limits and notes appropriate speech, thought process, thought content, judgment, memory, behavior, fund of knowledge, appearance and mood. The treatment plan included starting gabapentin 300 Qhs and Wellbutrin XL 150 q.d. The record also mentions that Patient B stopped clonidine and started Norvasc[26] for her blood

[25] Sleep apnea refers to a potentially serious sleep disorder in which breathing repeatedly stops and starts.

[26] Norvasc (amlodipine) is a calcium channel blocker, which can be used to treat high blood pressure and chest pain (angina).

pressure.

37. On or about June 20, 2017, Patient B returned to Respondent, reporting relapsing on alcohol, having hallucinations, being manic, and going to a facility. She was prescribed antipsychotics (Invega),[27] but it had been discontinued. The mental status exam was within normal limits. Patient B's recorded diagnosis was bipolar disorder.[28] The treatment plan included initiating Lamictal[29] to 50 q.d., restarting Invega 6 q.d., as well as Celexa 40 q.d., and gabapentin[30] 600 QID. The record also mentions referral to Quotient test (test for ADHD).

38. On or about June 30, 2017, Patient B returned to Respondent, reporting that she had returned to work. Patient B's listed diagnosis now included bipolar disorder and ADHD. The treatment plan included starting Adderall XR 20 Qam, continued titration of Lamictal to 100, decreasing Celexa to 20 q.d., as well as continuation of Ambien 10 Qhs, Invega 6 Qhs, and gabapentin 600 QID.

39. On or about July 28, 2017, Patient B returned to Respondent, reporting worsening depression. The mental status exam noted a more depressed mood, but it was otherwise within normal limits. Patient B's listed diagnosis now included a mood disorder not otherwise specified, and ADHD. The treatment plan included starting Dexedrine[31] 10 BID, increasing Celexa to 40 q.d., increasing Lamictal to 100 BID, continuing gapapentin 600 QID,[32] continuing Ambien 10 Qhs, discontinuing Invega, and discontinuing Adderall.

40. On or about August 25, 2017, Patient B returned to Respondent, reporting stopping Lamictal, which made her dizzy and did not improve her mood. The mental status exam noted a

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[27] Invega (paliperidone) is an antipsychotic, which can be used to treat schizophrenia and schizoaffective disorder.

[28] Bipolar disorder refers to a disorder associated with episodes of mood swings ranging from depressive lows to manic highs.

[29] Lamictal (lamotrigine) is an anticonvulsant, which can be used to treat seizures and bipolar disorder.

[30] Gabapentin is an anticonvulsant and nerve pain medication, which can be used to treat seizures and pain caused by shingles.

[31] Dexedrine (dextroamphetamine) is a stimulant, which can be used to treat ADHD.

[32] Q.i.d. means four (4) times a day.

discouraged mood but was otherwise within normal limits. The treatment plan included increasing Celexa to 60 q.d., continuing Dexedrine 10 BID, gabapentin 600 QID, Ambien 10 Qhs, and discontinuing Lamictal.

41. On or about September 25, 2017, Patient B returned to Respondent, reporting no complaint. The mental status exam was within normal limits. The treatment plan was unchanged.

42. On or about October 16, 2017, Patient B returned to Respondent, reporting that her blood pressure was running high, and having an injured eye blood vessel. There is no blood pressure reading in the medical records for this visit. The mental status exam was within normal limits. The treatment plan included unchanged medications and a recommendation to have her blood pressure examined by her primary care provider.

43. On or about November 13, 2017, Patient B returned to Respondent, reporting having had knee surgery and that her blood pressure was now controlled. The mental status exam was within normal limits. The treatment plan was unchanged.

44. On or about December 4, 2017, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

45. On or about December 20, 2017, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

46. On or about January 4, 2018, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

47. On or about January 25, 2018, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

48. On or about February 26, 2018, Patient B returned to Respondent, reporting no complaints and being close to one year of sobriety. The mental status exam was within normal

limits. The treatment plan was unchanged and included Celexa 60 q.d., Dexedrine 10 BID, gabapentin 600 QID, and Ambien 10 Qhs.

49. On or about March 26, 2018, Patient B returned to Respondent, reporting no complaints, but some knee pain. The mental status exam was within normal limits. The treatment plan was unchanged.

50. On or about April 16, 2018, Patient B returned to Respondent, reporting taking Celexa 40 q.d. and that it was working well. The medical records do not indicated a mental status exam or diagnoses. The treatment plan was unchanged.

51. On or about May 16, 2018, Patient B returned to Respondent, reporting some loss of function in her leg. The mental status exam was within normal limits. No diagnoses are listed. The treatment plan was unchanged.

52. On or about July 10, 2018, Patient B returned to Respondent, reporting that she had received an epidural, which helped her with pain management, which in turn helped her with depression and concentration. The mental status exam was within normal limits. The treatment plan noted Celexa 40 q.d., Dexedrine 10 BID, gabapentin 600 QID, but not Ambien.

53. On or about August 29, 2018, Patient B returned to Respondent, reporting no complaints. The medical records do not indicate a mental status exam. The treatment plan included unchanged medications and a recommendation to exercise one hour every day.

54. On or about October 10, 2018, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

55. On or about November 20, 2018, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged.

56. On or about January 8, 2019, Patient B returned to Respondent, reporting no complaints, but indicated that she was being scheduled for a spinal block. The mental status exam was within normal limits. The treatment plan was unchanged.

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57. On or about February 26, 2019, Patient B returned to Respondent, reporting no complaints. The mental status exam was within normal limits. The treatment plan was unchanged and included Celexa 40 q.d., Dexedrine 10 BID, gabapentin 600 QID, and Ambien 10 Qhs.

58. During the course of Respondent's care and treatment of Patient B, from on or about August 10, 2016 through February 26, 2019, Respondent failed to perform and/or failed to document having performed urine drug screens despite the following risk factors: Patient B had a history of alcohol (and possibly more substance) use disorder; Patient B was receiving prescriptions for Ambien above the maximum recommended dose; Patient B was receiving Ambien from multiple medical providers; Patient B was at times prescribed opioids in addition to Ambien, despite a history of alcohol use disorder; and Patient B was also prescribed stimulants since June 30, 2017, another medication of abuse.

59. During the course of Respondent's care and treatment of Patient B, from on or about August 10, 2016 through February 26, 2019, Respondent failed to obtain and/or failed to document having obtained CURES report(s) despite prescribing multiple controlled substances to Patient B, Patient B's history of alcohol use disorder, and Patient B's history of using controlled substances.

60. During the course of Respondent's care and treatment of Patient B, from on or about August 10, 2016 through February 26, 2019, Respondent failed to check CURES report(s) until at least on or about February 28, 2019.

61. During the course of Respondent's care and treatment of Patient B, from on or about August 10, 2016 through February 26, 2019, Respondent prescribed Ambien despite Patient B's history of alcohol use disorder and co-concomitant opioid prescriptions. Respondent also prescribed Ambien to Patient B, in a manner inconsistent with medical records. Respondent failed to adequately document the additional doses of Ambien he prescribed to Patient B. Respondent failed to inquire and/or failed to document having inquired about other medical providers who may have been prescribing Ambien.

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- Between August 10, 2016 and September 23, 2016, Patient B had four (4) prescriptions for #30 Ambien 10.

- Between October 3, 2016 and November 23, 2016, Patient B had six (6) prescriptions for #30 Ambien 10.

- On October 18, 2017, Patient B filled a 30-day supply of Ambien 5 Qhs from a Dr. M.

- From June 20, 2017 until December 20, 2017, Patient B received nine (9) 30-day supplies of Ambien in seven (7) months.

-On July 6, 2018 and on July 14, 2018, Patient B was prescribed 30-day supplies of Ambien 10 Qhs.

- In 2018, Patient B received seventeen (17) prescriptions for 30-day supplies of Ambien 10 Qhs in twelve (12) months, filled at four (4) different pharmacies.

-In January 2019, Patient B received three (3) prescriptions for 30-day supplies of Ambien 10 Qhs in one (1) month.

62. Respondent committed repeated negligent acts in his care and treatment of Patient A and Patient B, including, but not limited to:

a. Paragraphs 9 through 61, above, are hereby incorporated by reference and realleged as if fully set forth herein;

b. Respondent failed to obtain a CURES report at Patient A's initial encounter (intake);

c. Respondent failed to obtain a CURES report of Patient A until at least February 28, 2019;

d. Respondent failed to assess and/or failed to document having assessed Patient A's suicide risk;

e. Respondent failed to check and/or obtain and/or document Patient A's physical examinations and vital signs;

f. Respondent failed to obtain a CURES report at Patient B's initial encounter (intake);

g. Respondent failed to obtain a CURES report of Patient B until at least February

28, 2019;

h. Respondent failed to adequately assess and/or failed to document having adequately assessed the specific details of Patient B's substance use history and/or disorder

i. Respondent failed to adequately obtain and/or failed to document having adequately obtained urine drug screens of Patient B;

j. Respondent failed to evaluate and/or justify, and/or failed to document having evaluated and/or justified the additional doses of Ambien Respondent prescribed to Patient B; and

k. Respondent failed to assess and/or failed to document having assessed Patient B's suicide risk.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

63. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 63583 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 9 through 62, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

64. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 63583 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 63, above, which are hereby incorporated by reference 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. A 63583, issued to Respondent Scott Dragosh Ispirescu, M.D.;

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

3. Ordering Respondent Scott Dragosh Ispirescu, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 19 2022

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

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