ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
TAN N. TRAN
Deputy Attorney General
State Bar No. 197775
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6535
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOSEPH SANDOR HARASZTI, M.D.** **2810 E. Del Mar Blvd., Suite 8A** **Pasadena, CA 91107-4323** **Physician's and Surgeon's Certificate No. G 37865,** Respondent.	Case No. 800-2019-058543 **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 August 21, 1978, the Board issued Physician's and Surgeon's Certificate Number G 37865 to Joseph Sandor Haraszti, 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 April 30, 2024, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 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.

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from,

prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. 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:

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(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.

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. 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.

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COST RECOVERY

11. 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

(Gross Negligence/Repeated Negligent Acts – 6 Patients)

12. Respondent Joseph Sandor Haraszti, M.D. is subject to disciplinary action under section 2234, subdivisions (b) and (c), of the Code for the commission of acts or omissions involving gross negligence/repeated negligent acts in the care and treatment of Patients 1, 2, 3, 4, 5, and 6.[1] The circumstances are as follows:

Patient 1

13. Patient 1 (or "patient") is a sixty-three-year-old male who treated with Respondent from approximately 2002 through 2020.[2] Patient 1 came to Respondent for treatment of various conditions, including depression, anxiety, pain disorder, and other psychological conditions including Attention Deficit Hyperactivity Disorder (ADHD). Patient 1 had no history of prior mental health treatment apart from his internist having recently started him on Xanax (a.k.a. alprazolam, a controlled substance/benzodiazepine for anxiety). The patient also reported having a pain management specialist who started him on methadone (a synthetic opioid agonist used for chronic pain and opioid dependence).

14. It is unclear from the patient's chart when Respondent started prescribing opiate analgesics for Patient 1. However, per CURES (Controlled Substance Utilization Review and Evaluation System, a drug monitoring database for Schedule II through V controlled substances dispensed in California) for the timeframe from June 2013 through June 2020,[3] Respondent was prescribing to Patient 1 dangerous controlled medications, both opioid analgesics (morphine, oxycodone, and hydrocodone) and benzodiazepines (alprazolam, clonazepam, temazepam, and

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[1] The patients are identified by number to protect their privacy.

[2] These are approximate dates based on the records available to the Board. Although some of the treatment of the patients described herein may be beyond the statute of limitations (SOL), specific departures identified in this Accusation are from 2015 through 2020, dates of treatment which are within the SOL, and any references to treatment beyond the SOL are made for the sake of completeness.

[3] Based on the CURES data, 2018 was the year in which Respondent prescribed to Patient 1 the most medication, including morphine and oxycodone, and four benzodiazepines (alprazolam, clonazepam, temazepam, and lorazepam).

lorazepam).[4] Also per CURES, during the time period from June 2013 through June 2020, Patient 1 was also receiving multiple prescriptions for controlled substances from four other practitioners, with the majority of the prescriptions for opioid analgesics.

15. Respondent did not obtain adequate historical information to establish a legitimate medical indication for prescribing opioid analgesic pain medication to Patient 1. There was no documentation that Respondent physically examined the patient apart from recording blood pressure and pulse on several occasions. There are no imaging studies or prior records to corroborate the patient's history or to look for problems that might be treatable with more specific treatment than an opioid analgesic. There is no documentation of informed consent relative to his prescribing opioid analgesics to this patient and in combination with benzodiazepines, and no documentation that Respondent obtained a urine drug screen prior to prescribing opioid analgesics to this patient. Respondent did not have an opiate/pain medication treatment agreement (e.g., in order to explain to the patient about the dangers of controlled medications, not to obtain multiple prescriptions/combinations from different doctors, to only use one pharmacy, etc.), with Patient 1 and failed to check CURES to see if other doctors were also prescribing dangerous controlled medications to the patient.[5]

16. Furthermore, there is no documentation that Respondent was aware of the risks of prescribing both opioids and benzodiazepines to Patient 1, and no evidence that Respondent attempted to wean either the opioids or benzodiazepines. Also, there is no evidence that Respondent considered non-pharmacological treatments for this patient's pain.

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[4] Alprazolam is used for treatment of anxiety disorders and is a benzodiazepine of intermediate duration. Clonazepam is also used for treatment of anxiety and certain seizure disorders, and is a benzodiazepine of intermediate to long duration. Temazepam is used for treatment of insomnia and is a benzodiazepine of intermediate duration. Lorazepam is also used to treat anxiety and sleep disorders. These are all scheduled drugs and also considered dangerous drugs pursuant to Code section 4022.

[5] There were often lengthy gaps in treatment as the patient would at times return to Respondent after years of a "hiatus." Therefore, checking CURES would have informed Respondent the prescriptions Patient 1 may have obtained from other practitioners during these gaps. Also, CURES and billing codes showed that Respondent prescribed to Patient 1 a large number of controlled substances from March 2014 through June 2020, yet documentation (e.g., visit/progress notes) were sparse or nonexistent to corroborate these visits/prescriptions. There is no evidence that Respondent ever checked CURES during the years he prescribed opioids to this patient, even after checking that CURES was mandated in California in October 2018.

17. Respondent's care and treatment of Patient 1, as described above, represents an extreme departure from the standard of care for:

A. Respondent's failure to properly evaluate Patient 1 prior to prescribing controlled substances for him;

B. Respondent's failure to appropriately monitor Patient 1 while prescribing controlled substances to him; and,

C. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 1.

Patient 2

18. Patient 2 (or "patient") is a seventy-two-year-old female who treated with Respondent from approximately 2002 through 2019.[6] Patient 2 had various conditions including bipolar disorder and depression, chronic pain, and she experienced significant weight gain during this time period. Per CURES, for the timeframe from June 2013 through June 2020, Respondent was prescribing to Patient 2 hundreds of prescriptions for opioids (e.g., mostly hydrocodone (opiate analgesic)), benzodiazepines (alprazolam (for anxiety), diazepam (for anxiety), and flurazepam (for insomnia)), and stimulants (phentermine (weight loss drug) and methylphenidate (a.k.a., Ritalin for ADHD); all dangerous drugs pursuant to section 4022 of the Code). During this time period, there were also approximately thirty-eight prescriptions written for Patient 2 from five other practitioners, thirty-three of which were for opioids.

19. There is no evidence that Respondent had an adequate treatment plan or treatment goals for his prescribing of opioid analgesics to this patient. There is no documentation that Respondent ever prepared a formal pain assessment to specifically describe the nature and extent of Patient 2's pain and the impact her pain had upon her functioning. There is no documentation that Respondent ever physically examined the patient regarding her chronic pain problem, and no

[6] Although Respondent appeared to be prescribing opioid painkillers (e.g., hydrocodone/Lortab) to Patient 2 from the beginning of her treatment (e.g., 2003-2004), in his initial evaluation of the patient, Respondent did not mention the patient having a problem with pain, and references to the patient's chronic pain in the medical records are infrequent and inadequate to justify the amount of medication Respondent prescribed to the patient over the years.

documentation of an informed consent being given to the patient relative to Respondent's prescribing of opioid analgesics to Patient 2. There is no evidence that Respondent obtained a urine drug screen prior to prescribing opioid analgesics to this patient, and no evidence that Respondent checked CURES prior to prescribing opioid analgesics to this patient, or performed urine drug testing and CURES reviews on-going during his monitoring of the patient over the years.

20. There appeared to be lengthy gaps in treatment, as visit/progress notes from 2014 through 2019 were sparse. For example, although there was evidence that Respondent was continuing to prescribe controlled substances to Patient 2 during this time period, there were no progress/visit notes to support those prescriptions. Respondent also did not perform a urine drug screen[7] for Patient 2 despite treating the patient for many years, and there is no evidence that Respondent checked CURES, even after it was mandated in October 2018.[8]

21. Respondent prescribed an opioid analgesic (hydrocodone) for Patient 2, concurrent with his prescription of three benzodiazepines (alprazolam, diazepam, and flurazepam) from 2013 through 2019.[9] However, there was no evidence that Respondent recognized the potential adverse interactions between these medications, as there was no evidence that Respondent attempted to wean the patient off the opioid or benzodiazepine medications.

22. There was no adequate documentation that Respondent had a treatment plan or treatment goals for his prescribing of opioid analgesics to this patient, and Respondent did not have a pain medication treatment agreement with Patient 2. Also, there is no evidence that Respondent considered non-pharmacological treatments for Patient 2's chronic pain (e.g., physical therapy), and there is no evidence that Respondent coordinated/consulted with Patient 2's primary physician or other providers/specialists.

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[7] Only one set of laboratory results could be located in the voluminous medical record, despite Respondent's treatment of Patient 2 for nearly two decades.

[8] Had Respondent checked CURES, he would or should have seen that Patient 2 had obtained a total of 38 prescriptions (including 33 prescriptions for opioid analgesics) for controlled substances from five other providers from 2015 through 2018.

[9] Co-prescribing opioids and benzodiazepines simultaneously to a patient is a risky combination due to the potential for adverse interactions between these medications. In August 2016 the FDA issued a Boxed warning against combining prescriptions for opioids and benzodiazepines, stating that when used in combination, there is a serious risk of death.

23. Respondent's care and treatment of Patient 2, as described above, represents an extreme departure from the standard of care for:

A. Respondent's failure to properly evaluate Patient 2 prior to prescribing controlled substances for her;

B. Respondent's failure to appropriately monitor Patient 2 while prescribing controlled substances to her; and,

C. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 2.

Patient 3

24. Patient 3 (or "patient") is a thirty-year-old male who treated with Respondent from approximately July 2019[10] to September 2020. Patient 3 indicated that he had ADHD and was taking many medications. There is no initial evaluation in the medical record authored by Respondent. Per Respondent, he was treating Patient 3 for acute psychotic disorder.

25. During this time period, Respondent prescribed to Patient 3 numerous controlled substances, mostly stimulants and psychotropic medications, such as Adderall, trazodone, phendimetrazine, armodafinil, phentermine, and temazepam.[11] There is no initial evaluation from Respondent to guide the analysis, and there is limited history to be gleaned from the sparse progress notes. There is no diagnostic formulation and there is no clear treatment plan with respect to the prescription of the multiple controlled substances. Respondent did not have any of Patient 3's hospital records, nor did he have any records from the patient's previous treating psychiatrist. The notes contained in the chart do not provide an adequate assessment of the patient's target symptoms, treatment goals, his response to treatment with the various medications, and whether the patient was tolerating the medications and taking them as directed.

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[10] The first note provided by Respondent for Patient 3 is dated July 18, 2019, almost a year after Respondent began prescribing medication to Patient 3.

[11] Of all the controlled substances Respondent issued to Patient 3, most were for phendimetrazine, a stimulant recommended for short term use, and phentermine, another stimulant weight loss drug. All listed medications are dangerous drugs pursuant to Code section 4022.

26. Although Respondent was prescribing stimulants to Patient 3 (who had a history of psychosis), the medical record does not show that Respondent adequately monitored the patient for symptoms of psychosis, nor was there any documentation that Respondent monitored the patient's blood pressure.[12] Respondent was prescribing to Patient 3 "alerting" medications (e.g., modafinil and armodafinil, drugs approved for excessive daytime sleepiness), while the patient was prescribed concomitant stimulants (e.g., Adderall and phendimetrazine). Although there was no documentation, Respondent asserts that he tried to diagnose the cause of the patient's daytime somnolence. There was also no documentation that Respondent took adequate steps to understand the cause of Patient 3's symptoms of insomnia.

27. Respondent was not adequately monitoring Patient 3's treatment with psychotropic medications, as some of his prescriptions were issued quite close together (e.g., within a week of each other), despite the patient's prescriptions being written for a 30-day supply. Respondent failed to utilize CURES[13] to monitor the patient's compliance with treatment relative to his prescription of controlled substances to the patient, and there was no documentation of a urine drug screen performed on this patient. The sparse progress notes do not provide an adequate assessment of the patient's target symptoms, treatment goals, his response to treatment with the various medications, and whether he was tolerating the medications and taking them as directed.[14]

28. Respondent's care and treatment of Patient 3, as described above, represents an extreme departure from the standard of care for:

A. Respondent's failure to appropriately monitor Patient 3 while prescribing psychotropic medications to him; and,

B. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 3.

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[12] It is important to monitor a patient's blood pressure while they are taking stimulants such as Adderall, as such stimulant medications can cause significant in systolic and diastolic blood pressure.

[13] Respondent corroborated in his interview with the Board that he never checked CURES during his treatment of Patient 3.

[14] Comparing the visit notes in the medical record with Respondent's Patient billing ledger showed that there appeared to be at least 25 missing notes for dates of service/treatment for Patient 3.

Patient 4

29. Patient 4 (or "patient") is a forty-eight-year-old female who treated with Respondent from approximately January 2018 to April 2020. The patient had various conditions including depression, anxiety, and somatic complaints. Patient 4 also reported using "recreational drugs" (e.g., cocaine, marijuana, etc.) as a minor.

30. Respondent prescribed multiple controlled substances for Patient 4, including three different benzodiazepines (alprazolam, clonazepam, and temazepam).[15] The medical record does not provide adequate justification for this combination of medicines, and for Respondent's prescribing of other benzodiazepines to Patient 4 concurrently. Moreover, Respondent failed to adequately use CURES to monitor Patient 4's compliance with treatment relative to his prescription of controlled substances to her, as the CURES database showed that other practitioners were also prescribing same or similar controlled substances to Patient 4 during the time period the patient was treating with Respondent. Also, Respondent prescribed to Patient 4 antidepressants, which may have caused the patient to have side effects (e.g., weight gain, increase in blood pressure and high lipids count on blood testing, etc.), but Respondent failed to adequately monitor/record the patient's vital signs (e.g., weight, blood pressure, pulse, respirations, temperature) during her treatment.

31. Respondent's medical record keeping for Patient 4 is also inadequate. For example, the date of the initial evaluation is unclear and there is inadequate documentation of an appropriate examination prior to Respondent's prescribing various medications, including controlled substances, for Patient 4 and nothing to suggest that an informed consent (e.g., a thorough explanation of the medications, including the risks and benefits associated with the medications) was given to the patient for the various medications Respondent prescribed to her.

[15] Alprazolam or Xanax, is used for treatment of anxiety disorders and is a benzodiazepine of intermediate duration. Clonazepam or Klonopin, is also used for treatment of anxiety and certain seizure disorders, and is a benzodiazepine of intermediate to long duration. Temazepam or Restoril, is used for treatment of insomnia and is a benzodiazepine of intermediate duration. All three medications are controlled substances and dangerous drugs pursuant to section 4022 of the Code.

Moreover, there is evidence that Respondent continued to prescribe controlled medications to Patient 4, despite there being no visit/progress notes to corroborate said prescriptions.[16]

32. Respondent's care and treatment of Patient 4, as described above, represents deviations from the standard of care (or simple negligence) for:

A. Respondent's failure to appropriately monitor Patient 4 while prescribing psychotropic medications to her; and,

B. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 4.

Patient 5

33. Patient 5 (or "patient") is a twenty-four-year-old male who treated with Respondent from approximately January 2014 through September 2019. Respondent performed a mental status examination on Patient 5 during the initial psychiatric evaluation, but there was no mention of vital signs or any physical evaluation in the typed report. Respondent diagnosed Patient 5 with ADHD (Attention Deficit Hyperactivity Disorder) and probable bipolar 2 disorder with "history of polydrug experimentation."

34. During his treatment of Patient 5, Respondent prescribed to this patient multiple stimulants (e.g., Adderall, Vyvanse, methylphenidate (Ritalin)).[17] Respondent also concomitantly, prescribed benzodiazepines (e.g., clonazepam, alprazolam, lorazepam), to Patient 5, but there was no evidence that Respondent was adequately monitoring these prescriptions. For example, there were lengthy gaps in treatment, missed appointments, and other "red flags," which showed noncompliance or other suspicious activity by the patient.[18] Respondent also failed to

[16] For example, in the eight months between Respondent's visits with Patient 4 in January and September 2018, records show that Respondent issued to Patient 4 eight prescriptions for diazepam (Valium), five prescriptions for clonazepam (Klonopin), and a prescription for lorazepam (Ativan) all three controlled substances are benzodiazepines and dangerous drugs pursuant to section 4022 of the Code.

[17] These three drugs are controlled stimulants used to treat ADHD. They are dangerous drugs pursuant to section 4022 of the Code.

[18] For example, the sparse progress notes showed a gap in treatment of approximately 14 months from May 2018 to July 2019. However, there is evidence to show that Respondent continued to write multiple prescriptions of controlled medications to this patient in the interim between the visits. Moreover, comparing the visit notes in the medical record with the Patient Ledger (billing record) shows approximately 13 missing notes for dates of service between 2015

adequately utilize CURES to monitor if the patient was receiving controlled substances from other practitioners.[19]

35. Respondent's care and treatment of Patient 5, as described above, represents deviations from the standard of care (or simple negligence) for:

A. Respondent's failure to appropriately monitor Patient 5 while prescribing psychotropic medications to him; and,

B. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 5.

Patient 6

36. Patient 6 (or "patient") is a sixty-two-year-old female who treated with Respondent from approximately January 2018 through August 2020, mainly for depression and anxiety. Respondent performed a mental status examination on Patient 6, but Respondent did not check vital signs or perform a physical exam on this patient.

37. During his treatment of Patient 6, Respondent prescribed to the patient multiple prescriptions for both opioid analgesics (e.g., hydrocodone), as well as benzodiazepines (e.g., alprazolam), and CURES showed that during the time frame in which Respondent issued these prescriptions to Patient 6, seven other practitioners were also issuing prescriptions for opioids (including hydrocodone) to her.

38. Respondent failed to adequately utilize CURES to monitor if Patient 6 was receiving controlled substances from other practitioners. The medical record for Patient 6 is inadequate and showed large gaps between office visits during which time Respondent continued prescribing the patient controlled substances. Moreover, comparing the visit notes in the medical record with the Patient Ledger (billing record) showed approximately 14 missing notes for dates of service between 2018 through 2020.

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through 2019.

[19] A progress note, dated July 11, 2019, showed that Respondent had "confronted" the patient with the fact that he [Patient 5] had received similar medications from different doctors. Apparently, Respondent may have been informed of this "doctor shopping" by the patient via a call from a pharmacy because Respondent did not recall ever checking CURES for Patient 5.

39. Respondent's care and treatment of Patient 6, as described above, represents deviations from the standard of care (or simple negligence) for:

A. Respondent's failure to appropriately monitor Patient 6 while prescribing psychotropic medications to him; and,

B. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 6.

SECOND CAUSE FOR DISCIPLINE

(Excessive Prescribing – 6 Patients)

40. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Joseph Sandor Haraszti, M.D. is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1, 2, 3, 4, 5, and 6 above.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prior Examination or Medical Indication – 6 Patients)

41. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Joseph Sandor Haraszti, M.D. is subject to disciplinary action under section 2242 of the Code, in that Respondent furnished dangerous drugs to Patients 1, 2, 3, 4, 5, and 6 above, without conducting an appropriate prior examination and/or medical indication.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records – 6 Patients)

42. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Joseph Sandor Haraszti, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1, 2, 3, 4, 5, and 6 above.

DISCIPLINARY CONSIDERATIONS

43. To determine the degree of discipline, if any, to be imposed on Respondent Joseph Sandor Haraszti, M.D., Complainant alleges that on August 24, 2012, in a prior disciplinary

action titled *In the Matter of the First Amended and Supplemental Accusation Against Joseph Sandor Haraszti, M.D.* before the Medical Board of California, in Case Number 11-2007-188043, Respondent's license was placed on probation for a period of two years for allegations of gross negligence, repeated negligent acts, failure to maintain adequate/accurate medical records, violation of professional confidence, and general unprofessional conduct, pursuant to section 2234, subdivisions (b) and (c), and sections 2266 and 2263, of the Code. That Decision is final and is incorporated 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 37865, issued to Respondent Joseph Sandor Haraszti, M.D.;

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

3. Ordering Respondent Joseph Sandor Haraszti, 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: AUG 04 2022

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