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

In the Matter of the Accusation Against: **JENNIFER MARIE BREWER, M.D.** **1500 Franklin Street** **San Francisco, CA 94109-4523** **Physician's and Surgeon's Certificate No. A 123445,** Respondent.	Case No. 800-2019-058986 **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 November 1, 2012, the Medical Board issued Physician's and Surgeon's Certificate Number A 123445 to Jennifer Marie Brewer, 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, 2022, 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 2220 of the Code states:

> Except as otherwise provided by law, the Board may take action against all persons guilty of violating this chapter. The Board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the Board shall have all the powers granted in this chapter for these purposes including, but not limited to:
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> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the Board that a physician and surgeon may be guilty of unprofessional conduct. The Board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The Board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.
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> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.
>
> (c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2228.1 of the Code states.

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

made on and after July 1, 2019, in any of the following circumstances:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Section 2234 of the Code states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

9. Section 2263 of the Code states: The willful, unauthorized violation of professional confidence constitutes unprofessional conduct.

10. Section 2264 of the Code states: The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

11. 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.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

13. Abilify (aripiprazole) is an antipsychotic medication. It works by changing the actions of chemicals in the brain. Abilify is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression).

14. Aristada is an extended-release aripiprazole injection used to treat schizophrenia. This medication can decrease hallucinations and improve concentration.

15. BuSpar is a trade name for buspirone hydrochloride, an anti-anxiety agent that is chemically or pharmacologically related to benzodiazepines, barbiturates, or other sedative/anxiolytic drugs. The concomitant use of BuSpar with other CNS-active drugs should be approached with caution. BuSpar is a dangerous drug as defined in section 4022 of the Code.

16. Clonazepam, known by the trade name Klonopin, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 of the Code and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system (CNS) depressant drugs.

17. Clozapine is used to treat the symptoms of schizophrenia in people who have not been helped by other medications or who have tried to kill themselves and are likely to try to kill or harm themselves again. Clozapine is in a class of medications called atypical antipsychotics.

18. Cogentin, the trade name for Benztropine, is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs (antipsychotics such as chlorpromazine/haloperidol). Benztropine belongs to a class of medication called anticholinergics that work by blocking a certain natural substance (acetylcholine).

19. Dextromethorpan is used to relieve coughs due to colds or influenza (flu). It should not be used for chronic cough that occurs with smoking, asthma, or emphysema or when there is an unusually large amount of mucus or phlegm (flem) with the cough.

20. Haldol, a trade name for haloperidol, is a major tranquilizer used for the management of manifestations of psychotic disorders. It is a dangerous drug within the meaning of Code section 4022. Adverse reactions associated with the use of Haldol include Extrapyramidal Symptoms (EPS), insomnia, restlessness, anxiety, agitation, and hypotension. EPS can be categorized generally as Parkinson's-like symptoms, akathisia, or dystonia.

21. Invega Sustenna is the trade name for paliperidone palmitate, an atypical antipsychotic indicated for the treatment of schizophrenia in adults.

22. Lamictal, the trade name for lamotrigine, is used alone or with other medications to prevent and control seizures. It may also be used to help prevent the extreme mood swings of bipolar disorder in adults. Lamotrigine is known as an anticonvulsant or antiepileptic drug.

23. Latuda, the trade name for lurasidone, is a medication that works in the brain to treat schizophrenia. It is also known as a second-generation antipsychotic (SGA) or atypical antipsychotic. Lurasidone rebalances dopamine and serotonin to improve thinking, mood, and behavior.

24. Metformin is used to treat type 2 diabetes. Metformin is in a class of drugs called biguanides. Metformin helps to control the amount of glucose (sugar) in the blood. It decreases the amount of glucose one absorbs from food and the amount of glucose made by the liver. Metformin also increases the body's response to insulin, a natural substance that controls the amount of glucose in the blood.

25. Mirtazapine, known by the trade name Remeron, is used to treat depression. Mirtazapine belongs to a group of medicines called tetracyclic antidepressants. These medicines work in the (CNS) to make certain chemicals in the brain stronger. This medicine is available only with your doctor's prescription.

26. Olanzapine, also known by the brand name Zyprexa, is a psychotropic agent that belongs to the thienobenzodiazepine class. It is a dangerous drug as defined by Code section 4022. Zyprexa is indicated for the management of the manifestations of psychotic disorders, the treatment of schizophrenia, and the short-term treatment of the acute manic episodes associated with bipolar I disorder.

27. Omeprazole, known by the trade name Prilosec, is an antisecretory compound. It is a dangerous drug within the meaning Code section 4022. Prilosec is indicated for the short-term treatment of active duodenal ulcers, erosive esophagitis, and symptomatic gastroesophageal reflux disease, to maintain healing of erosive esophagitis, and for the long-term treatment of pathological hypersecretory conditions.

28. Propranolol is a beta-blocker used to treat heart problems and help with anxiety. It is also known by the trade name Bedranol.

29. Prozac, a trade name for fluoxetine hydrochloride, an antidepressant, is a dangerous drug within the meaning of Code section 4022. Prozac is an antidepressant agent chemically unrelated to tricyclic, tetracyclic, or other available antidepressant agents. A significant percentage (12 to 16%) of patients on Prozac experienced anxiety, nervousness, or insomnia. In general, the maximum dose of fluoxetine should not exceed 80 mg per day.

30. Risperdal, a trade name for risperidone, is an antipsychotic agent of the benzisoxazole class and is indicated for the management of the manifestations of psychotic disorders. It is a CNS active drug and a dangerous drug as defined in section 4022 of the Code.

31. Wellbutrin, a trade name for bupriopian hydrochloride, an antidepressant of the aminoketone class, is a dangerous drug within the meaning of Code section 4022. Wellbutrin is an antidepressant agent chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents. The incidence of seizures associated with Wellbutrin may exceed that of other marketed antidepressants by as much as fourfold. Wellbutrin SR is the sustained release form of Wellbutrin.

FACTUAL ALLEGATIONS

32. At all relevant times, Respondent was a physician and surgeon in California, board certified in Psychiatry and Family Medicine.

33. At all relevant times, Respondent was employed as a physician at the Felton Institute in San Francisco. Their stated mission is to respond to human needs by providing cutting edge, evidence-based mental health and social services and treatments. The job duties of Respondent at

the Felton Institute included, but were not limited to, providing complex medication management for San Francisco's seriously mentally ill, urban population.

34. On August 24, 2019, the Board received an anonymous online complaint against Respondent. The allegations in the complaint included, but were not limited to, Respondent seeing clients without generating records, and consulting with R.R., a "medical intuitive" who uses a photograph of a patient to advise regarding medication and mental health treatment. That online complaint further alleged that Respondent made changes to the treatment plans of patients based on the feelings of R.R.

35. R.R. maintains a website describing her services. On the website "About" page, the following description of her services is found:

> My company, **REDACTED**, believes that the body has the ability to heal itself at the physical, emotional and spiritual level. Our physical symptoms are merely physical manifestations of how we feel on the inside. To change physical symptoms, one must address their thoughts and beliefs. Once this starts to occur, the body starts to function better and the individual has a deeper sense of who they are.

36. R.R. would provide a report to Respondent of her feelings and recommendations and often cited "spiritual entities" as a cause of physical manifestations of diseases.

37. Respondent consulted and worked with "medical intuitive" R.R. from June 2019 through September 2019. Respondent used her time and the patients' data and obtained a report from R.R. She made treatment decisions consistent with R.R.'s suggestions about discontinuing antidepressants and mood stabilizers, and initiating sage tea, garlic, cilantro, etc., in a precise dosing form, in the medication section of the progress notes.

38. As part of her consultation with "medical intuitive" R.R., Respondent transmitted personal and confidential information and medical histories, including a photograph of patients, over an unsecure line or network.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 1[1])

39. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c) and/or 2234, subdivision (d), and/or 2266 of the Code in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 1. The circumstances are as follows:

40. Patient 1 is a 21-year-old male with a working diagnosis of schizoaffective disorder, depressed. Patient 1 was seen by Respondent at the Felton Institute from July 12, 2018 to January 25, 2022.[2]

41. Patient 1 was having difficulty thinking and had intrusive interfering thoughts with limited insight and judgment. He was struggling to go about daily affairs due to his psychosis.

42. Despite the indications that Patient 1 was not capable of weighing the benefits and risks of sharing his protected health information with a non-licensed provider that could influence his treatment, on July 25, 2019, Patient 1 signed a "Medical Intuitive Informed Consent" that would provide for his photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care practitioner, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

43. On July 27, 2019 a Comprehensive Informational Chart was created by R.R. for Patient 1 and transmitted to Respondent. Among the statements contained in the chart is a section listing "Areas of Concern". Within that section, the chart states "Spiritual Entities" as the area that has manifested the most physical disease.

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[1] Numbers are used to protect patient privacy. Respondent may learn the names of the patients through the discovery process.

[2] All dates are approximate, and as reflected in the medical records.

44. On August 1, 2019, Patient 1 returned to discuss his "integrative consult" with Respondent. At that visit, Respondent discontinued Buspar and recommended sage tea twice a day consistent with R.R.'s recommendation. Patient 1 then stopped treatment with Respondent until August 26, 2020.

45. Patient 1 reported that he relates his symptoms to injuries that happened when he was a teenager, including head injuries. However, despite a head injury being a possible contributor to his symptoms, it was not documented by Respondent in his diagnosis or in a plan for further work-up.

46. Respondent's care and treatment of Patient 1 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea, garlic, and hawthorn to address Patient 1's schizoaffective disorder.

B. Respondent sought out and accepted advice from a non-licensed health care worker who stated that "it feels good to cut his dosage in half SLOWLY" of Invega Sustenna, which was being used to treat Patient 1's schizophrenia.

C. Respondent exposed Patient 1's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

D. Respondent exploited her position of power over Patient 1 and abused the trust placed in her by Patient 1 to advance her own agenda involving R.R.

E. Respondent failed to distinguish between pharmacology and supplements in Patient 1's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

F. Respondent did not tell Patient 1 that he was subject to unproven treatments. There is no data whatsoever that sage tea, garlic or hawthorn is effective in the treatment of psychotic disorders or schizophrenia.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 2)

47. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 2. The circumstances are as follows:

48. Patient 2 is a 21-year-old female diagnosed with schizophrenia. After several hospitalizations in 2013, she had not been hospitalized for 6 years. In 2019, she graduated from community college, and was well enough to travel out of the country.

49. Patient 2 was prescribed 300 mg of Clozaril in August 28, 2018. In April 2019, Respondent documented a reduction in Clozaril from 300 mg to 200 mg. No explanation of the reduction is contained within the medical record.

50. On July 17, 2019, Patient 2 signed a "Medical Intuitive Informed Consent" that would provide for her photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care practitioner, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

51. Medical records from August 21, 2019, document a further reduction in Clorazil to 150 mg.

52. In November 2019, Respondent provided a letter to the disability office at San Francisco State University requesting that Patient 2's stress and workload be reduced.

53. On December 30, 2019, Patient 2 was hospitalized after discontinuing her medications and reportedly making paranoid comments and phone calls to police.

54. Respondent's care and treatment of Patient 2 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea and vitamin D to treat Patient 2's schizoaffective disorder.

B. Respondent sought out and accepted advice from a non-licensed health care worker who stated that "here are the products, numbers and information that I see" followed by Clozapine 150mg, half the dose which was previously effective for Patient 2.

C. Respondent exposed Patient 2's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

D. Respondent exploited her position of power over Patient 2 and abused the trust placed in her by Patient 2 to advance her own agenda involving R.R.

E. Respondent failed to distinguish between pharmacology and supplements in Patient 2's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

F. Respondent did not tell Patient 2 that she was subject to unproven treatments. There is no data whatsoever that sage tea or vitamin D is effective in the treatment of psychotic disorders or schizophrenia.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 3)

55. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep

adequate and accurate records, in her care and treatment of Patient 3. The circumstances are as follows:

56. Patient 3 is a 23-year-old male diagnosed with social phobia with secondary Major Depressive Disorder and Obsessive Compulsive Disorder.

57. Lorazepam and clonazepam were prescribed by Respondent. However, there is no note in the chart of the increased prescriptions of clonazepam in July and August.

58. On August 15, 2019, Patient 3 signed a "Medical Intuitive Informed Consent" that would provide for his photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care practitioner, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

59. On August 19, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 3, which does not correspond to any recognized medical framework. In the chart, R.R. documented her feelings about Patient 3's prescribed medicines and their effectiveness. R.R. also recommended several supplements including cilantro extract, chlorella, and vitamin D.

60. Respondent's care and treatment of Patient 3 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker to treat Patient 3's mental health disorders.

B. Respondent failed to distinguish between pharmacology and supplements in Patient 3's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

C. Respondent did not tell Patient 3 that he was subject to unproven treatments. There is no data whatsoever that cilantro extract, chorella, or vitamin D is effective in the treatment of mental health disorders.

D. Respondent exposed Patient 3's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

E. Respondent exploited her position of power over Patient 3 and abused the trust placed in her by Patient 3 to advance her own agenda involving R.R.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 4)

61. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 4. The circumstances are as follows:

62. Patient 4 is a 29-year-old transgender person diagnosed with schizophrenia, PTSD with psychotic features, and depression.

63. On August 6, 2019, Respondent treated Patient 4. In the progress notes, Respondent documented that Patient 4 believes she may be able to kill people with her mind. Instead of trying evidence-based strategies to treat Patient 4, which had not yet been tried, such as a long acting injectable and mood stabilizers, Respondent discussed incorporating "medical intuitive" R.R. into her treatment.

64. Respondent then incorporated the feelings of R.R. into the treatment plan of Patient 4, including her "feeling" that an FDA approved anti-psychotic medication would make Patient 4 sleepy and will not stop the voices.

65. Respondent's care and treatment of Patient 4 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea and vitamin D to treat Patient 4's schizophrenia, PTSD with psychotic features, and depression.

B. Respondent sought out and accepted advice from a non-licensed health care worker who stated that "here are the products, numbers and information that I see" followed by sage tea and smudging with a white sage stick for hearing voices and intrusive thoughts. R.R. also commented on Latuda, which was prescribed for schizophrenia, "this just feels like it will make her really sleepy and won't stop the voices".

C. Respondent exposed Patient 4's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

D. Respondent exploited her position of power over Patient 4 and abused the trust placed in her by Patient 4 to advance her own agenda involving R.R.

E. Respondent failed to distinguish between pharmacology and supplements in Patient 4's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

F. Respondent did not tell Patient 4 that she was subject to unproven treatments. There is no data whatsoever that sage tea or vitamin D is effective in the treatment of psychotic disorders or schizophrenia.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 5)

66. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 5. The circumstances are as follows:

67. Patient 5 is a 27-year-old woman diagnosed with schizoaffective disorder, bipolar type.

68. On July 31, 2019, Patient 5 signed a consent to have "medical intuitive" R.R. consult on her case and would provide for her photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent.

69. On August 15, 2019, Respondent documented in progress notes that the treatment plan was to decrease Lamictal then stop, consistent with the opinion of R.R. There is no documentation of the rationale for discontinuing the Lamictal. The progress notes show that Patient 5 had her symptoms under fair to good control at that examination despite having two recent hospitalizations.

70. On August 22, 2019, Patient 5 reported that she feels out of control and moves her neck to feel connected between her mind and body. This is psychotic behavior and Respondent failed to recognize it.

71. On September 16, 2019, Patient 5 self-admitted to the hospital after feeling suicidal. Respondent did not document the discharge summary, diagnosis, or discharge medications. Moreover, Respondent did not document a consideration that the tapering of Abilify or the discontinuation of lamotrigine were an issue with Patient 5's deteriorating health.

72. Respondent's care and treatment of Patient 5 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea and other dietary supplements to treat Patient 5's schizophrenia.

B. Respondent sought out and accepted advice from a non-licensed health care worker who opined on Patient 5's medical treatment including prescriptions.

C. Respondent exposed Patient 5's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

D. Respondent exploited her position of power over Patient 5 and abused that trust placed in her by Patient 5 to advance her own agenda involving R.R.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 6)

73. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 6. The circumstances are as follows:

74. On October 12, 2016, Respondent examined Patient 6, a then 47-year-old male with a longstanding history of polysubstance abuse, a diagnosis of borderline personality disorder and anti-social personality, and multiple severe medical problems including hypercoagulability of unknown etiology and a history of dormant hepatitis C. Patient 6 stated that "I used to beat up people, I used to be very violent, I used to rob people." Patient 6 endorsed chronic suicidal ideation but that he would never act on it because of the "fear of God."

75. On January 19, 2019, Patient 6 admitted that he bought heroin two weeks earlier in order to overdose, then changed his mind. Patient 6 overdosed on tranquilizers as a teen that placed him in a coma for five days, and his last suicide attempt was in 2017, when he tried to hang himself with a rope.

76. On March 27, 2019, Respondent decreased the clonazepam dosage prescribed to Patient 6 with the intent of monthly dosage decreases.

77. On May 21, 2019, Respondent examined Patient 6, two weeks post-hospitalization in which Patient 6 woke from a three-day coma. Respondent switched Patient 6 from Invega to

risperidone, when one of the primary concerns of the hospital team was elevated sugars, and it seemed that Patient 6 had a diabetic coma, which is life-threatening. Risperidone and olanzapine are both known to promote metabolic syndrome, which can lead to diabetes.

78. On July 24, 2019, Patient 6 signed a "Medical Intuitive Informed Consent" that would provide for his photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent." The Consent inaccurately states that it was signed on July 24, 1968. The date 7-24-19 is written next to the original date in different handwriting.

79. On July 25, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 6. R.R. recommended the following products be considered in Respondent's prescribing to Patient 6: collinsonia root (vein rebuilder); HVS metals (heavy metal detox); white sage smudge stick; Risperdal (voices); Gabapentin ("Three times daily feels like too much. SLOWLY taper off when ready"); Nicorette gum; and Klonopin ("Slowly taper off .5mg each month"). R.R. also wrote, "It doesn't feel like his body can handle any internal herbs and that is why I chose the above products compared to sage tea for entities and cilantro for heavy metals."

80. R.R. considered the following to be harmful products for Patient 6: Methadone ("slowly taper off when able"); mirtazapine ("slowly taper off when able"); and Buspar ("slowly taper off when able").

81. On August 6, 2019, Patient 6 claimed that he spent three days at San Francisco General Hospital, but Respondent never requested records of the hospitalization so Respondent has no information whether the stay was medical or for psychiatric services. Respondent also discontinued the use of Buspar less than two weeks after the tapering of that medicine was recommended by R.R.

82. On August 14, 2019, Respondent examined Patient 6, noting slurred speech and "out of it" affect, aware that Patient 6 told Respondent during the past few visits that he wanted to use drugs, yet Respondent failed to order a urine toxicology screen. Respondent failed to

address Patient 6's recent hospitalizations and emergency services contacts since Respondent tapered Patient 6's clonazepam usage. Respondent restarted gabapentin/Neurontin, which Patient 6 reported gave him "severe memory loss," but Respondent did not revisit lithium or other mood stabilizers. Patient 6 has had auditory hallucinations, disorganization, and intermittent paranoia, yet Respondent did not offer a psychotic diagnosis.

83. Respondent's care and treatment of Patient 6 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of collinsonia root; HVS metals; white sage smudge stick; Risperdal; Gabapentin; Nicorette gum; and Klonopin to address Patient 6's mental health.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested, "It doesn't feel like his body can handle any internal herbs and that is why I chose the above products compared to sage tea for entities and cilantro for heavy metals."

C. Respondent sought out and accepted advice from a non-licensed health care worker who suggested that Respondent taper the dosage and use of the following medicines prescribed to Patient 6: Methadone; Mirtazapine; and Buspar.

D. Respondent failed to get a valid Consent for Patient 6, who appears not to have been oriented to the year.

E. Respondent failed to maintain accurate and adequate records for Patient 6. For example, on January 15, 2019, Patient 6 was prescribed olanzapine 40 mg, and then on January 29, 2019 it was decreased to 30 mg. Yet, according to the records, on February 19, 2019, Patient 6 was supposedly taking 20 mg of olanzapine.

F. Respondent failed to make a diagnosis of psychosis, whether that be psychosis due to substance (cocaine) or schizoaffective disorder, while at the same time prescribing clozapine/Clozaril, which is almost always only used for psychosis due to its side effect profile.

G. Respondent exposed Patient 6's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

H. Respondent exploited her position of power over Patient 6 and abused the trust placed in her by Patient 6 to advance her own agenda involving R.R.

I. Respondent failed to distinguish between pharmacology and supplements in Patient 6's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

J. Respondent did not tell Patient 6 that he was subject to unproven treatments. There is no data whatsoever that sage tea is effective in the treatment of psychotic disorders or schizophrenia.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 7)

84. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 7. The circumstances are as follows:

85. On August 11, 2016, Respondent commenced treating Patient 7, who was then a 38-year-old female with bipolar 1 disorder with psychotic features and a history of hospitalizations, including a Health and Safety Code section 5150 confinement from January to May 2015 for suicidal ideation.

86. On March 20, 2019, Respondent noted that Patient 7 had been hospitalized in February 2018 for two weeks with mixed episode, suicidal ideation. Patient 7 was to commence Abilify Maintena 300 mg and continued with Lamictal 200 mg for daily mood stabilization.

87. On August 8, 2019, Patient 7 signed a "Medical Intuitive Informed Consent" that would provide for her photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent." The medical records inaccurately state that the Consent was signed on August 1, 2019.

88. On August 8, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 7. R.R. recommended the following products be considered in Respondent's prescribing to Patient 7: Hawthorn (viral killer/immune stabilizer); Albiza complex (viral drainage for upper body); cilantro extract (bipolar 1 support); sage tea (viral killer/immune support/cholesterol/behavior); Hepatrophin PMG (liver rebuilder); garlic forte (cholesterol support); Aristada (anti-psychotic) 884 mg every two months; and Lamictal (mood stabilizer) 200 mg.

89. On October 10, 2019, Patient 7 noted that she has not yet tried the sage tea and cilantro drops recommended by R.R. Patient 7 claimed that she was feeling overwhelmed by everything, but would take the products if she had a reminder. The sage tea and cilantro drops were added to Patient 7's pharmacological regimen, along with Aristada 884 mg q2 months, and Lamictal 200 mg daily.

90. On November 7, 2019, Patient 7 reported that she tried the sage tea but did not like the flavor. The medicine regime was continued.

91. Respondent's care and treatment of Patient 7 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of hawthorn; Albiza complex; cilantro extract; sage tea; Hepatrophin PMG; garlic forte; Aristad; and Lamictal to help Patient 7's bipolar 1 disorder and suicidal ideations.

B. Respondent added a new regimen (tea and drops) to Patient 7 who was already overwhelmed with basic diet and exercise, and who had a history of medication non-compliance leading to hospitalization.

C. Respondent failed to maintain accurate and adequate records for Patient 7.

D. Respondent exposed Patient 7's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

E. Respondent exploited her position of power over Patient 7 and abused the trust placed in her by Patient 7 to advance her own agenda involving R.R.

F. Respondent failed to distinguish between pharmacology and supplements in Patient 7's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

G. Respondent did not tell Patient 7 that she was subject to unproven treatments. There is no data whatsoever that sage tea and cilantro extract are effective in the treatment of bipolar 1 disorder and mood disorders.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 8)

92. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 8. The circumstances are as follows:

93. On December 14, 2017, Respondent first examined Patient 8, a 27-year-old African American male with schizoaffective disorder, bipolar type. He was still hearing voices, had poor hygiene, dirty fingernails and tears in clothing, was malodorous, and smoked cigarettes

and marijuana daily. Patient 8 dropped out of school in 10th grade. Patient 8 was taking Invega Sustenna 234 mg monthly.

94. On December 11, 2018, Respondent decided to commence Patient 8 on a trial of Risperdal 3 mg daily, and discontinue the Invega Sustenna, even though Patient 8 had a prior Risperdal claim and had been waiting to get money from that claim.

95. On October 3, 2019, Respondent noted in the records that Patient 8 "drinks some alcohol when he's feeling paranoid." Yet, in the section titled "Substance History" Respondent notes that Patient 8 denies alcohol use.

96. On August 15, 2019, Patient 8 signed a "Medical Intuitive Informed Consent" that would provide for their photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent." Respondent also noted that she would commence Patient 8 on a trial of "sage tea bid for voices."

97. On August 19, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 8. R.R. recommended the following products be considered in Respondent's prescribing to Patient 8: sage tea; garlic; Biost; and Invega Sustenna. R.R. wrote, "From my perspective, it doesn't feel like [Patient 8] needs more prescription support if he is going to use Sage Tea regularly."

98. Respondent's care and treatment of Patient 8 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea; garlic; Biost; and Invega Sustenna to address Patient 8's schizoaffective disorder.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested, "From my perspective, it doesn't feel like [Patient 8] needs more prescription support if he is going to use Sage Tea regularly."

C. Respondent prescribed Risperdal to Patient 8 even though Patient 8 apparently had an adverse reaction to it in the past. Respondent prescribed Risperdal even though there was a history of a "Risperdal claim" without any documentation of exploring the reaction.

D. Respondent failed to maintain accurate and adequate records as Patient 8's records have the Patient 8 both reporting alcohol use and "denies alcohol use."

E. Respondent exposed Patient 8's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

F. Respondent exploited her position of power over Patient 8 and abused the trust placed in her by Patient 8 to advance her own agenda involving R.R.

G. Respondent failed to distinguish between pharmacology and supplements in Patient 8's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

H. Respondent did not tell Patient 8 that he was subject to unproven treatments. There is no data whatsoever that sage tea is effective in the treatment of psychotic disorders or schizophrenia.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 9)

99. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 9. The circumstances are as follows:

100. On April 25, 2018, Respondent first examined Patient 9, a then 52-year-old gender neutral ambulatory individual who had emigrated from Japan in 2001. Patient 9 had a prior diagnoses of depression, anxiety, bipolar disorder, PTSD and borderline personality disorder.

Patient 9 also had prior medical history of chronic pain syndrome and hospitalization. At that time, Patient 9 was taking lorazepam 0.5 mg tid; Propranolol 20 mg bid; lexapro 10 mg; abilify 5 mg; zolpidem 5 mg; and oxycodone 5 mg #30 or #60 monthly.

101. On March 14, 2019, Respondent spoke with Patient 9's primary care physician who stated that Patient 9 had recently violated a behavioral agreement, so the physician was in the process of transferring Patient 9 to an alternative treatment clinic.

102. On May 23, 2019, when talking with Respondent, Patient 9 became so angry when discussing mental health resource allocations that Patient 9 vomited mid-conversation.

103. On June 25, 2019, Patient 9 signed a "Medical Intuitive Informed Consent" that would provide for their photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

104. On June 27, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 9. R.R. recommended the following products be considered in Respondent's prescribing to Patient 9: sage tea; cilantro extract; Propranolol 20 mg; Lorazepam; Lantus; Glyburide; and Baclofen. R.R. considered Abilify and HCTZ to be "neutral" products to prescribe to Patient 9, and considered the following to be harmful products for Patient 9: zolpidem, fenofibrate, and oxycodone.

105. On July 18, 2019, Respondent started Patient 9 on sage tea twice a day and recommended stopping the use of zolpidem. On August 7, 2019, zolpidem was discontinued. Patient 9 also noted on this date that they had fired "five interns" or case managers handling their mental health matters.

106. Respondent's care and treatment of Patient 9 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea; cilantro extract; Propranolol 20 mg; Lorazepam; Lantus; Glyburide; and Baclofen to address Patient 9's depression, anxiety, and anger.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing zolpidem, fenofibrate, and oxycodone for Patient 9's depression, anxiety, and anger and then replacing that known medicine with sage and cilantro teas.

C. In light of Patient 9's diagnosis of borderline personality disorder, and their subsequent behavior over the course of treatment, Respondent failed to attempt to characterize the affective instability, severe attachment issues, and brief psychotic periods in a way that could be easily communicated to other health care professionals.

D. Respondent exposed Patient 9's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

E. Respondent exploited her position of power over Patient 9 and abused the trust placed in her by Patient 9 to advance her own agenda involving R.R.

F. Respondent failed to distinguish between pharmacology and supplements in Patient 9's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

G. Respondent did not tell Patient 9 that they were subject to unproven treatments.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 10)

107. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed

to keep adequate and accurate records, in her care and treatment of Patient 10. The circumstances are as follows:

108. On August 29, 2018, Respondent treated Patient 10, a then 23-year-old female to male transgender patient suffering from persistent depressive disorder and borderline personality traits. Patient 10, who previously had a two-week hospitalization for a psychotic episode, claimed not to have heard voices since October 2017. Patient 10 had a history of cutting and pill usage and was undergoing court-mandated treatment. Patient 10 had been using cannabis on a daily basis since age 14 and commenced using methamphetamine in 2016, but frequency of usage is not recorded.

109. On August 29, 2018, Patient 10 was being treated with Wellbutin XL 300 mg, Remeron 15 mg, gabapentin 300 mg twice a day for anxiety, and testosterone.

110. Respondent continued to treat Patient 10, meeting with him almost monthly, and on December 11, 2018, Respondent prescribed Latuda 20 mg.

111. On June 25, 2019, Patient 10 signed a "Medical Intuitive Informed Consent" that would provide for his photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent." Respondent discontinued Patient 10's use of Latuda.

112. On June 26, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 10. R.R. recommended the following products be considered in Respondent's prescribing to Patient 10: sage tea; cilantro extract; cataplex D; gabapentin 300 mg bid; Propranolol 20 mg three times daily; and testosterone. R.R. considered Latuda 40 mg to be a neutral product to prescribe to Patient 10.

113. R.R. considered the following to be harmful products for Patient 10: Wellbutrin and Remeron.

114. On July 31, 2019, Respondent discussed with Patient 10 his increasing consumption of sage tea and the use of cilantro tea as a way to clear any damage from past heavy metal exposure. Respondent also discussed the plan to decrease Remeron and Wellbutrin.

115. On September 25, 2019, Patient 10 presented requesting a stimulant; admitted to not taking the gabapentin and propranolol as needed when feeling anxious, and admitted to not consuming the sage and cilantro teas.

116. Respondent wrote in the records, "Today we confronted his not following the med regimen thus far. We discussed at length the barriers to following recommendations and the reason for each recommendation made. Will discuss a trial of a stimulant after two weeks of following the below regimen as needed, which is more likely to support permanent positive changes in thought patterns. PLAN:- d/c Remeron as not taking- Ok to continue gabapentin 300 mg bid prn anxiety - propranolol 20 mg tid prn anxiety- d/c Wellbutrin- not taking - Cilantro extract three drops in hot water daily- Sage tea bid ... RTC 10 days."

117. Respondent next saw Patient 10 on November 25, 2019, and noted that "He still feels his brain is not functioning properly and thinks that stimulants might help him do the reading and studying and positive habits that would help him work through his trauma. He is motivated by treatment and states he is working independently on his own as well. Plan to trial a stimulant as agreed upon given improved adherence to medication regimen. PLAN:- Ok to continue gabapentin 300mg bid prn anxiety - propranolol 20mg tid prn anxiety - Cilantro extract three drops in hot water daily- Sage tea bid - Client now picking up meds independently - Ritalin 5mg take 1 tab bid #60 Script given today." Yet, Respondent never considered Patient 10's daily cannabis use as a possible cause of his concentration issues, nor does Respondent document the reason for the two month gap in appointments when she was supposed to see Patient 10 during the first week of October.

118. Respondent's care and treatment of Patient 10 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of sage tea; cilantro extract; cataplex D; gabapentin 300 mg bid; Propranolol 20 mg three times daily; to address Patient 10's depression, anxiety, and suicidal thoughts.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing Remeron and Wellbutrin for Patient 10's depression, anxiety, and suicidal thoughts and then replacing that known medicine with sage and cilantro teas.

C. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing Patient 10's use of Latuda; advice upon which Respondent acted.

D. Respondent made treatment in the medical model contingent upon following recommendations made by R.R.

E. Respondent failed to address Patient 10's daily cannabis use as a possible cause of his concentration issues, but used Ritalin as a reward for Patient 10's adherence to the sage and cilantro regimen.

F. Respondent exposed Patient 10's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

G. Respondent exploited her position of power over Patient 10 and abused the trust placed in her by Patient 10 to advance her own agenda involving R.R.

H. Respondent failed to distinguish between pharmacology and supplements in Patient 10's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

I. Respondent did not tell Patient 10 that he was subject to unproven treatments.

ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 11)

119. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed

to keep adequate and accurate records, in her care and treatment of Patient 11. The circumstances are as follows:

120. On November 22, 2017, Respondent examined Patient 11, a then 53-year-old divorced Ukrainian female with severe refractory depression, and chronic suicidal ideation. Patient 11 had been hospitalized 10 times in the last four years. At that time, Patient 11 was taking the following medications: Clonazepam 0.5 mg bid; Clozapine 25 mg bid; and Remeron 45 mg bid. Respondent decreased the Remeron to 30 mg bid; discontinued the clozapine; and commenced lithium 450 mg nightly.

121. On June 20, 2019, Respondent prescribed Wellbutrin 100 mg bid with dextromethorphan 30 mg daily for 1 week then bid.

122. On July 29, 2019, Patient 11 signed a "Medical Intuitive Informed Consent" that would provide for her photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

123. On July 30, 2019, Respondent conducted a house visit after Patient 11 failed to appear for the last two visits, and after Patient 11's sister called and said that Patient 11 had bought anti-freeze. The sister had taken Patient 11 to the emergency room three days earlier. Respondent found Patient 11 in the courtyard, pacing, gasping for breath, hand grabbing at chest, visibly uncomfortable. Patient 11 was minimally groomed, although appropriately dressed. Respondent continued the current pharmacological regimen, but added sage tea three times a day.

124. On July 31, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 11. R.R. recommended the following products be considered in Respondent's prescribing to Patient 11: HVS Metals, Cardio Plus (from Standard Process), wheat germ oil (from Standard Process); sage tea; Natto LP (from Allegan Nutrition); and Collagen C (from Standard Process). R.R. also wrote, "Lamictal feels really good for helping with depression symptoms from my perspective."

125. R.R. considered the following to be harmful products for Patient 11: Mirtazapine; Abilify; Clonopin; Wellbutrin; and Dextromethorpan.

126. On August 8, 2019, Respondent prescribed the following to Patient 11: Lamictal 25 mg daily for one week, increasing to 50 mg daily thereafter. Respondent also discontinued Wellbutin, while recommending the use of cilantro tea and continuing folic acid supplementation.

127. On October 24, 2019, Respondent prescribed HVS metals, 1 capful in 8 ounces of water once daily. Respondent documented in the records, "Medical intuitive consulted, consent signed previously and filed in chart. Recommendations for some supplements incorporated below. R/B/A discussed."

128. Respondent's care and treatment of Patient 11 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence, and/or failure to maintain accurate and adequate medical records, including, but not limited to, the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of HVS Metals, wheat germ oil, sage tea, collagen; and Lamictal to address Patient 11's depression, anxiety, and suicidal thoughts.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing Mirtazapine; Abilify; Clonopin; Wellbutrin; and Dextromethorpan for Patient 11's depression, anxiety, and suicidal thoughts.

C. Respondent exposed Patient 11's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

D. Respondent exploited her position of power over Patient 11 and abused the trust placed in her by Patient 11 to advance her own agenda involving R.R.

E. Respondent failed to distinguish between pharmacology and supplements in Patient 11's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

F. Respondent did not tell Patient 11 that she was subject to unproven treatments.

TWELFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence; Repeated Negligent Acts; Incompetence; Failure to Maintain Accurate and Adequate Records – Patient 12)

129. Respondent Jennifer Marie Brewer, M.D. is subject to disciplinary action under sections 2234 and/or 2234, subdivision (b), and/or 2234, subdivision (c), and/or 2234, subdivision (d), and/or 2266 of the Code, in that Respondent engaged in unprofessional conduct and was grossly negligent, and/or repeatedly negligent, and/or incompetent, and/or that she failed to keep adequate and accurate records, in her care and treatment of Patient 12. The circumstances are as follows:

130. In 2019, Patient 12 was a 38-year-old morbidly obese Ukrainian female who emigrated with her family as a child. Patient 12 had a long history of anxiety, depression, mood lability, psychosis, probable bipolar disorder, chronic suicidality, multiple suicide attempts, and between 50-100 psychiatric hospitalizations since she was 20-years old. Patient 12 was previously diagnosed with schizoaffective disorder – depressed type, and had been going to the hospital weekly for months for an ongoing issue of swallowing objects, and suicidal ideation.

131. On August 6, 2019, Patient 12 signed a "Medical Intuitive Informed Consent" that would provide for her photograph, date of birth, full name, case history and medical records to be sent by Respondent to R.R., an out-of-state non-licensed health care worker, who would review the information and consult with Respondent. Respondent did not sign the "Medical Intuitive Informed Consent."

132. On August 8, 2019, Respondent examined Patient 12, apparently for the first time. Respondent noted that Patient 12 was taking Haldol Dec 150 mg every four weeks; Prozac 90 mg; metformin 500 mg twice a day; Cogentin 1 mg twice a day; Omeprazole 40 mg daily; vitamin D3 2000 international units daily.

133. On August 9, 2019, Respondent received a Comprehensive Informational Chart from R.R. pertaining to Patient 12. R.R. recommended the following products be considered in Respondent's prescribing to Patient 12: core cilantro blend, sage tea; gelatin; disodium phosphate; metformin; vitamin D; and Haldol Decanoate.

134. R.R. considered the following to be harmful products for Patient 12: Prozac; Cogentin; Prilosec.

135. On August 13, 2019, Respondent documented that she discussed supplemental treatments with Patient 12, including the use of cilantro extract drops and sage tea. Respondent continued Patient 12 on Haldol 150 mg every four weeks, but discontinued Patient 12's use of Prozac, Cogentin and omeprazole, a medication prescribed by another treatment provider. Respondent did not consult with the other treatment provider before discontinuing the omeprazole.

136. On August 15, 2019, Respondent offered Patient 12 a working diagnosis of schizoaffective disorder, but did not prescribe a mood stabilizer. The documented review of systems and vitals notes a bilateral hand tremor, but the mental status examination fails to document any tremor.

137. On August 28, 2019, Respondent noted that Patient 12 "continues to express chronic suicidality." Respondent prescribed sage tea once daily and cilantro extract drops twice daily in water.

138. On September 2, 2019, Patient 12 overdosed on aspirin and was hospitalized at Langley Porter UCSF, and on September 5, 2019, Patient 12 was transported to the inpatient psychiatric ward.

139. Respondent's care and treatment of Patient 12 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence, and/or failure to maintain accurate and adequate medical records, including, but not limited, to the following:

A. Respondent sought out and accepted advice from a non-licensed health care worker who suggested the use of gelatin and cilantro to address Patient 12's depression, anxiety, and suicidal thoughts.

B. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing Prozac for Patient 12's depression, anxiety, and suicidal thoughts and then replacing that known medicine with gelatin and coriander.

C. Respondent sought out and accepted advice from a non-licensed health care worker who suggested discontinuing Patient 12's use of Congentin; advice upon which Respondent acted.

D. Respondent failed to address a working diagnosis of schizoaffective disorder with a mood stabilizer.

E. Respondent discontinued omeprazole for a morbidly obese patient, who presumably has comorbidities, and did so without consultation with the original prescriber.

F. Respondent exposed Patient 12's personal and confidential information and medical history when she transmitted it over an unsecure line or network to an out-of-state, non-licensed health care worker.

G. Respondent exploited her position of power over Patient 12 and abused the trust placed in her by Patient 12 to advance her own agenda involving R.R.

H. Respondent failed to distinguish between pharmacology and supplements in Patient 12's records by identifying supplements in the same manner as FDA-approved medications, without qualifiers or explanations.

I. Respondent did not tell Patient 12 that she was subject to unproven treatments.

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 A 123445, issued to Respondent Jennifer Marie Brewer, M.D.;

2. Revoking, suspending or denying approval of Jennifer Marie Brewer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jennifer Marie Brewer, 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;

4. Ordering Respondent Jennifer Marie Brewer, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: AUG 22 2022

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