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

In the Matter of the Accusation Against: **John Alexander Cervantes, M.D.** **923 Olive Street, Suite 3** **Santa Barbara, CA 93101** **Physician's and Surgeon's Certificate No. G 51144,** Respondent.	Case No. 800-2019-060170 **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 29, 1983, the Board issued Physician's and Surgeon's Certificate Number G 51144 to John Alexander Cervantes, M.D. (Respondent). That license 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 provisions of the California Business and Professions Code ("Code") unless otherwise indicated

4. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
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> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
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> (b) The administration and hearing of disciplinary actions.
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> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
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> (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.
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> (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 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.

6. 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

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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which 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 2228.1 of the Code states:

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

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

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

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

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

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

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

(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.

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9. 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 his or her 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.

10. 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.

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.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

12. Code section 4021 states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

13. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

DRUG DEFINITIONS

14. As used herein, the terms below will have the following meanings:

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous

ingestions of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under various brand names including, Intensol, Xanax, and Xanax XR. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Ambien" is a brand name for zolpidem. It is a central nervous system depressant.

"Belsomra" is a brand name for suvorexant, which is a medicine that is used to treat insomnia. Suvorexant is in a class of medications called orexin receptor antagonists. It works by blocking the action of a certain natural substance in the brain that causes wakefulness. It is a central nervous system depressant. It is contraindicated with the use of other medications for insomnia. It is a dangerous drug as defined in Code section 4022.

"Benzphetamine" is a stimulant and appetite suppressant that affects the central nervous system. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (b)(2), and a dangerous drug pursuant to Code section 4022.

"Buspar" is a brand name for buspirone. It is an anti-anxiety medication used to treat symptoms of anxiety disorders. It is a dangerous drug as defined in Code section 4022.

"Clonazepam" is a benzodiazepine-based sedative. It is a central nervous system depressant. It is generally used to control seizures and panic disorder. It is sold under the brand name Klonopin. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Code section 4022.

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

"Diazepam" is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It can produce psychological and physical dependence and should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. It is sold under the brand name Valium. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug as designated in Health and Safety Code section 4022.

"Fluoxetine" is an antidepressant and belongs to the group of medicines known as selective serotonin reuptake inhibitors (SSRIs). It is a dangerous drug as defined in Code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold under the brand name Neurontin, among others. It can have potentially harmful effects when combined with opioids. It is a dangerous drug as defined in Code section 4022.

"Lorazepam" is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is sold under the brand name Ativan among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Code section 4022.

"Risperdal" is a brand name for risperidone, an antipsychotic medication. It is generally used to treat schizophrenia, bipolar disorder, and irritability in people with autism. It is a dangerous drug pursuant to Code section 4022.

"SNRI" and "SSNRI" means selective serotonin and norepinephrine reuptake inhibitors, which are a class of medications that are effective in treating depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain. SNRIs work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression. SNRIs block the reabsorption (reuptake) of the neurotransmitters serotonin and norepinephrine in the brain. They are sold in several formulations, including desvenlafaxine (Pristiq), dloxetine (Cymbalta), levomilnacipran (Fetzima), and venlafaxine (Effexor XR). They are dangerous drug as defined in Code section 4022.

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"Temazepam" is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is sold under the brand names Restoril among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. Tramadol is sold under various brand names, including Ultram and ConZip. It is a Schedule IV controlled substance pursuant to the Federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"Trazodone" is an antidepressant medication. It is used to treat major depressive disorder, anxiety disorders, and in addition to other treatment, alcohol

dependence. It belongs to the serotonin receptor antagonist and reuptake inhibitors (SARIs) group of medications. It is a dangerous drug as defined in Code section 4022.

"Zolpidem" is a sedative drug primarily used to treat insomnia. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand name Ambien and Intermezzo. It is a Schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Code section 4022.

"Xanax" is a brand name for alprazolam.

COST RECOVERY

15. Section 125.3 of the Code states:

(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 licensee 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)

16. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in gross negligence in his care and treatment of Patients 1, 2 and 3.[1] The circumstances are as follows:

PATIENT 1:

17. Respondent started treating Patient 1, a then 38-year-old female patient, in March of 2007.[2] Respondent saw Patient 1 on a weekly to biweekly basis for medication management and therapy until May of 2019.

18. Respondent's medical record documentation and tracking of prescriptions for Patient 1 are handwritten and poorly legible.

19. During Respondent's care and treatment of Patient 1, she had been hospitalized in excess of 20 times, most following suicide attempts. She was seen by numerous psychiatrists during those hospitalizations who confirmed her bipolar disorder, type 1, mixed with rapid cycling. During Respondent's care and treatment of Patient 1, he prescribed over 70 different medications to Patient 1. Respondent prescribed multiple controlled substances to Patient 1, including benzodiazepines, opioids, and stimulants. He also prescribed anti-psychotic mood stabilizers and atypical antipsychotic medications to address her bipolar disorder and anti-depressants and anti-anxiety medications to address the mixed and rapid cycling components of

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1 through 3.

[2] Care rendered to the patients described herein prior to 2015 is for historical purposes or to illustrate Respondent's patterns and practices.

her bipolar condition. Respondent also prescribed medications to treat the patient's obsessive compulsive disorders, alcohol abuse issues, sleep issues and insomnia, tremors and shaking, as well as other medical conditions including diabetes, low thyroid, high blood pressure and weight gain.

20. Respondent documented Patient 1's drinking in the context of her alcohol use disorder on numerous occasions between March of 2016 and June of 2018.

21. Respondent documented Patient 1's non-compliance with medications and medication instructions on numerous occasions between September 2015 and November 2018.

22. Respondent's medical records for Patient 1 set forth numerous reference to self-harm and/or suicidality, including on March 17, 2016, May 12, 2016, July 8, 2016, July 27, 2017, September 28, 2017, and April 23, 2018. Respondent did not document the performance of a suicidal risk assessment during any of these encounters where self-harm and/or suicidality was noted.

23. Respondent did not review Patient 1's CURES reports or order any drug screens for Patient 1.

Inappropriate Prescribing of Benzodiazepines to Patient 1.

24. The standard of care requires a medical indication for a physician to prescribe medications to patients. When prescribing medications, a physician must perform an appropriate prior medical examination; identify a medical indication; maintain accurate and complete medical records, including treatments, medications; periodic reviews of treatment plans; and provide ongoing and follow-up medical care, as appropriate and necessary. Prescribing medications that have a potential for causing dependence requires careful monitoring for dangerous side effects. Monitoring includes review of CURES reports and obtaining periodic drug screens.

25. Throughout his care and treatment of Patient 1, Respondent prescribed benzodiazepines to Patient 1, including Klonopin/Clonazepam, Lorazepam, and Temazepan.

26. Patient 1's history of alcohol use disorder was first diagnosed by Respondent at the time of Patient 1's first visit with Respondent on March 1, 2007. Benzodiazepines are contra-indicated in patients with alcohol use disorder. Patient 1 had a substantial history of non-

compliance, non-response to treatment, self-harm, and suicidality. Benzodiazepines are dangerous medications that can be fatal in patients with frequent incidents of self-harm.

27. Respondent continued to prescribe benzodiazepines to Patient 1 despite reports of ongoing drinking. Respondent documented Patient 1's ongoing drinking on April 4, 2016, May 4, 2017, June 22, 2017, July 13, 2017, July 20, 2017, September 7, 2017, April 23, 2018, June 7, 2018, and June 28, 2018. Respondent continued to prescribe benzodiazepines to Patient 1 despite noting on October 6, 2016 that Patient 1 had been involved in a three vehicle accident. Respondent continued to prescribe benzodiazepines to Patient 1 despite noting on January 12, 2017 that she was also using cannabis. Respondent continued to prescribe benzodiazepines to Patient 1 despite noting on March 23, 2017 that she was altering her medications and not taking them as prescribed. On multiple occasions from 2015 through 2018, Respondent continued to prescribe benzodiazepines to Patient 1 despite her reports of non-compliance. Respondent failed to appropriately prescribe benzodiazepines to Patient 1. This is an extreme departure from the standard of care.

Inappropriate Prescribing of Opioids to Patient 1.

28. Opioids, like Tramadol, are contra-indicated in patients with an alcohol use disorder. Opioids are also dangerous medications that can be fatal in patients with frequent incidents of self-harm.

29. Respondent prescribed Tramadol to Patient 1 in April, May, July, August and September of 2018. As Patient 1's psychiatrist, Respondent prescribed Tramadol for her complaints of pain without appropriate justification. Respondent failed to perform an evaluation of Patient 1 for the use of opioid pain medication, including a physical examination, review relevant records, and ordering of diagnostic and radiologic tests. Respondent failed to formulate a differential diagnosis and treatment plan for prescribing opioid pain medication. Respondent prescribed Tramadol to Patient 1 despite her reports of ongoing drinking, the concomitant benzodiazepine prescriptions issued by Respondent, a concomitant opioid prescription by another provider, the patient's significant history of medication non-compliance, and the patient's

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significant history of suicidality and self-harm. This is an extreme departure from the standard of care.

30. When prescribing controlled medications, the standard of care requires that the physician monitor the patient for risks of abuse. Monitoring includes periodically reviewing CURES reports and performing drug screens. Reviewing Patient 1's CURES report would have alerted Respondent that Patient 1 was obtaining a prescription for opioids from another provider at the same time Respondent was prescribing opioids on July 19, 2018. Obtaining a CURES report would have also alerted Respondent that Patient 1 filled two prescriptions for benzodiazepines within a day of each other on October 8, 2018 and October 9, 2018, despite Respondent's medical records for Patient 1 reflecting that one prescription was issued. Obtaining drug screens, such as biological fluid testing, would have better informed Respondent of Patient 1's use of other substances of abuse. Respondent's failure to review Patient 1's CURES reports and obtain drug screens is an extreme departure from the standard of care.

Failure to Maintain Adequate and Accurate Medical Records as to Patient 1.

31. The standard of care requires that the physician document a patient's reported symptoms as well as the physician's assessment, evaluation, diagnosis, and treatment plan. The assessment and evaluation must include a mental status exam for psychiatric encounters. The documentation must also include explanations and justifications to support the diagnosis and treatment plan. The physician must also maintain an accurate medication list in the patient's medical records.

32. Patient 1 had a complex treatment and medication regimen. Respondent's medical records for Patient 1 were frequently illegible and lack the necessary examinations, assessments, and indications for the care and treatment provided. Respondent did not clearly track the patient's ongoing medications. Respondent's failure to maintain adequate and accurate medical records of his care and treatment of Patient 1 is an extreme departure from the standard of care.

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PATIENT 2:

33. In 2013, Respondent was providing psychiatric care and treatment of Patient 2, a then 69-year-old female patient.[3] Respondent's medical records and tracking of prescriptions for Patient 2 are handwritten, poorly legible, and difficult to follow.

34. During his course of treatment of Patient 2, Respondent mainly prescribed monthly refills of Lorazepam, Buspar, and Stelazine.

35. Of significance in 2013, Respondent prescribed two benzodiazepines (Lorazepam and diazepam) to Patient 2. He did not document any discussions with Patient 2 regarding the dangers of patients over the age of 65 taking benzodiazepines. Respondent documented an early refill of medications on one occasion in 2013. Respondent also documented that the patient was taking more Lorazepam than prescribed and that Respondent recommended that she not take more than 4 mg of Lorazepam per day. Respondent noted that he reviewed Patient 2's medical, non-psychiatric record wherein it was noted that her car was damaged. There was no explanation as to why the car was damaged or any inquiry by Respondent to Patient 2 as to the cause of the damage. In November 2013, Patient 2 told Respondent that she had transient ischemic attacks (TIAs) in the past which has caused dribbling from her mouth.

36. From March 2014 through May 2015, Respondent repeatedly prescribed Patient 2 two prescriptions for Lorazepam per month, one prescription for 130 tablets of Lorazepam 1 mg and another prescription for 10 tablets of Lorazepam 1 mg. Respondent noted that he did this because the patient "had problems with the pharmacy getting the extra ten 1 mg tablets of Lorazepam."

37. On June 7, 2015, Respondent prescribed an early refill of Lorazepam, Buspar, and Stelazine. The next day, June 8, 2015, Respondent noted in his progress notes that the patient was taking more medication than prescribed. He did not make any recommendations to address medication compliance.

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[3] At the time of his interview with the Board, Respondent stated that he began treating Patient 2 in 1989, and that she was diagnosed with schizophrenia, agoraphobia, and multiple phobias.

38. In July 2016, Patient 2 told Respondent that she had TIAs months ago and was taking aspirin and propranolol instead of Lisinopril, as well as Prilosec. Respondent recommended that she see her neurologist for the TIAs and he recommended that she take Buspar, Lorazepam, and Stelazine as prescribed.

39. In 2016 and 2017, Respondent documented that the patient had a tired appearance. In 2018, Respondent documented that the patient stated being tired, and on April 23, 2018, possibly dizzy.

40. Respondent permitted additional early refills of Patient 2's Lorazepam on multiple occasions, including September 26, 2016, November 21, 2016, January 16, 2017, February 18, 2019,[4] and September 4, 2019. Respondent failed to address that Patient 2 received Lorazepam from other providers in 2017, 2018, and 2019. Respondent also failed to address that Patient 2 received opioids from other providers while he concurrently prescribed benzodiazepines in 2016, 2017, and 2018. Respondent repeatedly documented that the patient claimed that her medications had been lost or stolen, including October 29, 2018, February 18, 2019, March 6, 2019, and April 10, 2019.

41. Respondent reviewed Patient 2's CURES Report on one occasion in 2018 and on one occasion in 2020.[5]

42. On October 18, 2019, Respondent documented a phone visit with Patient 2. He noted that the patient was being evaluated by Ventura Ambulatory Care for the purpose of tapering Lorazepam. The neurologist that the patient was seeing recommended citalopram and tapering Lorazepam by ¼ tablet every two weeks. In addition, she stopped taking Buspar and had an addiction counselor. The patient also stated that she was filing for bankruptcy and moving to her brother's apartment. Respondent noted that the patient's mood was anxious, she had tardive

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[4] On February 18, 2019, Respondent documented that the patient called stating that she lost 55 tablets of Lorazepam and that it is the patient's 12th request for early refill in the past few years, that there is concern for abuse, and that he will not give refill.

[5] Respondent did not document any reference to checking Patient 2's CURES Reports in 2015 through 2017, and 2019.

dyskinesia but an appropriate thought process and thought content. Respondent's plan included continuing to prescribe Lorazepam.

Failure to Recognize or Act on Patient 2's Signs of Abuse.

43. Respondent failed to recognize Patient 2's misuse of scheduled medications. Factors that Respondent should have considered included Patient 2's requests for early refills, her reports of lost prescriptions, her reports of taking more prescriptions than prescribed, Respondent's documentation of Patient 2's poor medication compliance, and being prescribed benzodiazepines by other providers. On October 18, 2019, another provider recommended that Patient 2 taper Lorazepam and she obtained an addiction counselor.

44. Respondent documented references to Patient 2's risk of abuse from being prescribed central nervous system depressants, including the reference to her car being damaged, her reports of being tired and dizzy, having poor concentration, and Respondent's description of the patient being frail on August 15, 2018. Respondent noted Patient 2's history of cerebrovascular incidents. Given Patient 2's age, being older than 65, she was more vulnerable to the risks of central nervous system depressants.

45. Respondent failed to adequately mitigate Patient 2's risk of abuse by failing to regularly review her CURES report and obtain drug screens. Patient 2 was prescribed benzodiazepines by other providers despite her history of already getting early refills of Lorazepam from Respondent. Further, Respondent failed to address Patient 2 being prescribed opioids by other providers while he was prescribing benzodiazepines. This created an additional risk of overdose. Respondent did not obtain drug screens despite the significant quantities of benzodiazepines that he prescribed, the patient's claims of lost and stolen medications, and the patient's requests for early medication refills.

46. Respondent's failure to recognize signs of abuse of benzodiazepines, failure to recognize the risk of abuse, and failure to mitigate the risk of abuse in Patient 2 is an extreme departure from the standard of care.

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Failure to Maintain Adequate and Accurate Medical Records for Patient 2.

47. Patient 2 had a complicated treatment regimen, including significant doses of benzodiazepines in a patient who was older than 65 years of age, had prior cerebrovascular incidents, and required an addiction counselor. Respondent had incomplete notes of his care and treatment. Further, his notes were frequently illegible. Respondent failed to adequately and accurately track Patient 2's ongoing prescriptions. Respondent's failure to maintain an adequate and accurate record of Patient 2's care and treatment is an extreme departure from the standard of care.

PATIENT 3:

48. Respondent provided psychiatric care and treatment to Patient 3 during the timeframe of 2010 through 2021. Respondent's medical records and tracking of prescriptions for Patient 3 are handwritten and poorly legible.

49. On October 4, 2010, Patient 3, a then 57-year-old female, presented to Respondent for treatment of anxiety and depression. Respondent reviewed the patient's stressors, social history, childhood history, occupational history, surgeries, medical history, family psychiatric history, trauma history, relationship history, substance history, and medication trial history. The patient was taking Xanax, 0.5 mg two to three times a day, Pristiq 50 mg, and Ambien 10 mg, which was noted to be ineffective. Respondent noted that Patient 3 had gone to a rehabilitation program for her use of opiates. Respondent's diagnosis was major depressive order. He increased her Pristiq dose to 100 mg and added Gabapentin.

50. Patient 3 continued to see Respondent on a near monthly basis through 2011 at which time Respondent continued to assess her and adjust her medications. In 2012, Respondent saw Patient 3 on three occasions, in February, May and September. At each of the those visits, Respondent noted his examination of the patient and prescribed Trazodone 100 mg, Risperdal 1 mg, and Pristiq 100 mg. Respondent saw Patient 3 from January 2013 to June 2013 at which time he examined her and adjusted her medications.

51. Patient 3 returned to see Respondent on January 15, 2015, at which time she reported marital stressor, anxiety, being separated, and taking Ambien. Respondent examined the patient

and prescribed Ambien 10 mg as well as Lorazepam 1 mg three times a day. On January 20, 2015, Respondent stopped the Lorazepam due to the patient feeling "fuzzy" and prescribed Klonopin 0.5 mg, three times a day.

52. On February 2, 2015, Respondent noted that the patient was coping. He increased the patient's Klonopin to 1 mg, three times a day and noted that she "should only take one benzodiazepine."

53. Despite the recommendation that Patient 3 only take one benzodiazepine, she continued to be prescribed Xanax by another provider, including February 2, 2015, February 3, 2015, February 13, 2015, March 4, 2015, April 6, 2015, May 4, 2015, and June 5, 2015. She was also prescribed another central nervous system depressant, Ambien, by another provider, on February 11, 2015, February 17, 2015, March 11, 2015, and March 20, 2015. Patient 3's medical records from Respondent's office do not address the prescriptions by other providers.

54. On February 13, 2015, Patient 3 had an emergency phone session with Respondent. She reported insomnia. Respondent assessed her as having insomnia and being at risk for depression. His plan included starting trazodone 50 mg to 150 mg. Respondent also noted that the patient could start taking fluoxetine 10 mg if she is depressed.[6]

55. Respondent continued to see Patient 3 on an approximate monthly basis throughout 2015, adjusting her medications based upon the patient's reports as to how she was doing and Respondent's assessments.

56. Of significance, on September 19, 2015, Patient 3 reported feeling numb and good, and having family stressors. Respondent noted that she had an appropriate appearance, behavior, thought process, thought content, but a numb mood. Respondent assessed the patient as coping well. He prescribed Klonopin .05 mg three times a day, and one in the evening, as well as Belsomra 20 mg, Ambien 10 mg, Trazodone 50 mg, Fluoxetine 20 mg.[7]

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[6] It is inappropriate to delegate to the patient the determination as to when to start an antidepressant.

[7] Respondent prescribed Patient 3 three scheduled central nervous system depressants for insomnia: Clonazepam, Belsomra, and Ambien, as well as a non-scheduled central nervous system depressant, Trazodone. In addition, Belsomra is contraindicated with the use of other medications for insomnia.

57. On January 21, 2016, Patient 3 reported a marital argument wherein she slapped her husband; she was arrested but that the charges were dropped. Respondent noted that the patient had an appropriate appearance, thought process, and thought content but was in a stressed mood. He noted that she was coping well. Respondent's progress note does not include a violence risk assessment despite the report of an act of violence and arrest.

58. Throughout 2016, Respondent continued to prescribe Ambien, Belsomra and clonazepam to Patient 3. On a monthly basis from May 2016 through December 2016, Patient 3 was also being prescribed benzphetamine by another provider. Respondent did not address the additional scheduled medication being prescribed by another provider.

59. Patient 3's CURES report reflects that she filled the monthly prescriptions for Ambien, Belsomra, and Clonazepam prescribed by Respondent, at Rite Aid pharmacy. Patient 3's CURES report also reflects that Patient 3 filled an additional monthly prescription for Clonazepam, prescribed by Respondent, at CVS Pharmacy in September, October, November, and December of 2016. Respondent noted one Clonazepam prescription per month in Patient 3's medical records, but he did not address the additional monthly prescription for clonazepam that Patient 3 was filling at a second pharmacy.

60. In 2017, Respondent continued to see Patient 3 and adjust her medications. In 2017, Patient 3's CURES report reflected that she simultaneously received opioid prescriptions from other providers while Respondent prescribed central nervous system depressants.[8] In addition, Patient 3 filled benzphetamine prescriptions in July, August, September, and October of 2017. Respondent did not address the risks of taking benzphetamine concurrently with the central nervous system depressants he prescribed.

61. On January 9, 2017, Respondent prescribed clonazepam 0.5 mg three times a day and one in the evening, trazodone 50 mg, and fluoxetine 40 mg. On January 10, 2017, Patient 3 filled a prescription prescribed by Respondent for 150 tablets (one-month supply) of clonazepam 0.5 mg at CVS Pharmacy. On January 11, 2017, Patient 3 filled a prescription prescribed by

[8] Patient 3 filled opioid prescriptions from other providers on January 7, 2017, January 22, 2017, January 23, 2017, January 26, 2017, February 13, 2017, August 14, 2017, August 22, 2017, September 1, 2017, October 30, 2017, and December 28, 2017.

Respondent for 300 tablets (two-month supply) of clonazepam 0.5 mg at Express Scripts pharmacy. Respondent noted a single one-month prescription for clonazepam in Patient 3's medical records and did not address the second two-month supply of clonazepam that Patient 3 obtained from a second pharmacy the following day.

62. On April 5, 2017, Respondent noted that Patient 3 was receiving prednisone for polymyalgia rheumatica and had poor sleep and anxiety. She stated that she was taking 8 mg of clonazepam. Respondent noted that she had an anxious mood, anhedonia, low energy, poor concentration, and guilt but an appropriate speech and thought process. Respondent's assessment was that the patient had developed a tolerance to clonazepam and the prednisone was contributing to her anxiety and insomnia. His plan included increasing trazodone to 50-150 mg. Respondent did not address that the patient was being prescribed 2.5 mg of clonazepam per day while taking 8 mg. Respondent did not address that Patient 3 met the criteria for a benzodiazepine disorder by taking more clonazepam than prescribed and having developed a drug tolerance. Respondent also failed to address that the maximum recommended dose of clonazepam is 4 mg per day, unless it is being used for the treatment of a seizure disorder.

63. On April 17, 2017, Respondent noted that the patient was taking more than twice her prescribed amount of clonazepam.

64. On May 15, 2017, Respondent noted that the patient was taking clonazepam 0.5 mg three times a day and once in the evening. This is inconsistent with Patient 3's CURES report, which reflects that she filled prescriptions prescribed by Respondent for 150 tablets of clonazepam 1 mg, on May 16, 2017 and 150 tablets of clonazepam 0.5 mg on May 29, 2017.

65. On August 2, 2017, Patient 3 reported taking more medications than prescribed, and not filling a prescription for clonazepam 4 mg. Respondent's plan was to re-order clonazepam 4 mg. Patient 3's CURES report reflects that she filled a prescription of 150 tablets of clonazepam 0.5 mg on August 3, 2017, and 120 tablets of clonazepam 1 mg on August 4, 2017. Respondent did not address this discrepancy.

66. For the five-month period of August to December 2017, Patient 3 repeatedly obtained early refills of her one month supply of clonazepam 1 mg from Respondent, ultimately obtaining

six months' supply in a five month period.[9] During that same time period, Respondent prescribed an additional 150 tablets of clonazepam 0.5 mg on August 3, 2017, and an additional 12 tablets of clonazepam 0.5 mg on November 6, 2017.

67. In 2018, Patient 3 continued to be seen by Respondent approximately once a month. He continued to adjust and manage her central nervous system depressants, prescribing a two-month supply of clonazepam 4 mg at a time. Patient 3 continued to receive early refills and received 7 prescriptions rather that 6 in 2018. Patient 3 filled prescriptions prescribed by Respondent for 240 tablets of clonazepam 1 mg on January 4, 2018, February 18, 2018, April 16, 2018, June 4, 2018, July 31, 2018, September 25, 2018 and November 15, 2018.

68. In April, May, August, September, and October of 2018, Patient 3 filled benzphetamine prescriptions prescribed by others while also being prescribed central nervous system depressants by Respondent. Respondent did not address the additional prescriptions with the patient.

69. In July 2018, Patient 3 reached the age of 65. Respondent did not adjust Patient 3's medications according to her age nor did he document any discussions with Patient 3 regarding medication risks in the ambulatory elderly.

70. In 2019, Respondent continued to see Patient 3 on a monthly basis and prescribe central nervous system depressants. The patient filled benzphetamine prescriptions in June, August, September, and October of 2019.

71. In 2020, Respondent continued to see Patient 3 on a monthly basis and prescribed central nervous system depressants.

Failure to Recognize or Act on Patient 3's Signs of Abuse.

72. At the time of Patient 3's first visit with Respondent, she was noted to have gone to a rehabilitation program for her opiate use. Throughout his care and treatment of Patient 3, Respondent documented many instances of medication non-compliance. On January 21, 2016, Patient 3 was involved in a violent incident with her husband and was arrested. From 2015

[9] Patient 3 filled one-month prescriptions for clonazepam 1 mg, prescribed by Respondent, on August 4, 2017, August 29, 2017, September 20, 2017, October 12, 2017, November 12, 2017, and December 10, 2017.

through 2020, Patient 3 was intermittently receiving prescriptions from other providers for scheduled stimulants and opioids, which are also medications of abuse, while continuing to receive scheduled medications from Respondent. In September, October, November, and December 2016, Patient 3 filled prescriptions of clonazepam, at times from multiple pharmacies, within days of each other. Likewise in January, February, and August 2017, Patient 3 filled prescriptions of clonazepam, at times from multiple pharmacies, within days of each other. Patient 3 obtained early refills of clonazepam in 2017 through 2020 and obtained early refills of Ambien in 2018. In 2017, Respondent noted that Patient 3 was taking more than the prescribed amount of clonazepam. At times, the doses were higher than the maximum recommended dose. Respondent also noted that Patient 3 was taking more clonazepam than intended and developed a tolerance to clonazepam, all of which indicates a possible benzodiazepine use disorder. On June 28, 2017, Respondent noted that Patient 3 was using cannabis despite being prescribed three scheduled medications and was intermittently receiving stimulants and opioids from other providers.

73. Respondent failed to recognize or act on signs of substance abuse. He failed to review Patient 3's CURES reports and failed to obtain drug screens. This is an extreme departure from the standard of care.

Inappropriate Prescribing of Central Nervous System Depressants to Patient 3.

74. Respondent engaged in excessive prescribing of central nervous system depressants, including benzodiazepines, despite Patient 3's significant risk factors. Patient 3 became an older adult during Respondent's care and treatment. This risk was compounded by her history of TIAs. In addition, Respondent at times prescribed three scheduled central nervous system depressants (clonazepam, Ambien, and Belsomra) to Patient 3, despite her age, that she had previously been in a rehabilitation program, that she had chronic non-compliance, was taking more scheduled medications than prescribed, and was obtaining prescriptions from more than one provider. Respondent's prescribing of central nervous system depressants to Patient 3 is an extreme departure from the standard of care.

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Failure to Maintain Adequate and Accurate Medical Records as to Patient 3.

75. Patient 3 had a complicated treatment regimen which included several scheduled medications prescribed by Respondent as well as stimulants and opioids prescribed by other providers. Respondent failed to properly track Patient 3's ongoing prescriptions. Respondent's documentation of prescribing controlled medications to Patient 3 was not consistent with Patient 3's CURES reports. Further, Respondent failed to note reviewing Patient 3's CURES reports until 2020. Respondent's documentation was often illegible and he failed to consistently document necessary examinations, evaluations, and assessments. Respondent's failure to maintain an adequate and accurate record of Patient 3's care and treatment is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

76. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

77. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

78. Respondent committed the following additional repeated acts of negligence:

PATIENT 1:

Inappropriate Prescribing of Phentermine to Patient 1.

79. Respondent restarted Patient 1 on phentermine on August 8, 2016, after last prescribing it on March 19, 2015. Respondent failed to document a physical examination, review of relevant records, order appropriate tests and evaluations, and formulate an adequate differential diagnosis and treatment plan to justify the use of phentermine. Respondent's prescribing of phentermine for Patient 1 is a simple departure from the standard of care.

Failure to Perform Suicidal Risk Assessment of Patient 1.

80. The standard of care requires physicians to perform a suicidal risk assessment when providing treatment to patients with depression, suicidality, engagement in self-harm, and those

who are prescribed medications that are often used in overdoses, such as benzodiazepines. Respondent failed to perform suicide risk assessments despite reports of self-harm and suicidality by Patient 1 on March 17, 2016, May 12, 2016, July 8, 2016, July 27, 2017, September 28, 2017, and April 23, 2018. This is a simple departure from the standard of care.

PATIENT 3:

Treatment of Patient 3's Psychiatric Conditions.

81. The standard of care requires that the physician make a good faith effort to obtain information necessary to establish whether a patient suffers from an illness or disorder. While treating medical conditions, the physician must perform risk assessments and monitor for side effects of treatment.

82. Respondent treated Patient 3's low mood with antidepressants over a ten-year period without periodically performing and documenting a risk assessment, despite her multiple risk factors, including her episode of marital violence resulting in arrest, her history of depression, medication non-compliance, using more than the recommended dose of medication, chronic prescriptions of opioids, benzodiazepines and other central nervous system depressants, her older age starting in 2018, and insomnia.

Respondent failed to periodically perform and document a risk assessment of Patient 3. This is a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

83. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1, 2, and 3, without an appropriate prior examination or medical indication therefor. The circumstances are as follows:

84. The allegations in the First and Second Causes for Discipline above, are incorporated herein by reference as if fully set forth.

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FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

85. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patients 1, 2, and 3. The circumstances are as follows:

86. The allegations in the First, Second, and Third Causes for Discipline above, are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct – Patients 1 and 2)

87. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that his action and/or actions represent unprofessional conduct and patient harm occurred as a result as to Patients 1 and 2. The circumstances are as follows:

88. As more fully discussed above, Respondent's excessive prescribing of controlled substances, including opioids, benzodiazepines, and other drugs caused specific harm to Patients 1 and 2 for purposes of Code section 2228.1 as further described below:

89. Patient 1 incurred harm as a result of Respondent's care and treatment. Patient 1 suffered numerous overdoses on scheduled medications prescribed by Respondent. In addition, Patient 1, who had an alcohol use disorder, had difficulty reaching and maintaining sobriety as a result of Respondent's overprescribing of benzodiazepines to her.

90. Patient 2 incurred harm as a result of Respondent's care and treatment. Respondent inappropriately and excessively prescribed benzodiazepines to Patient 2 without recognizing the risk of harm to her. Patient 2 suffered an overdose on benzodiazepines.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

91. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patients 1, 2, and 3.

92. The allegations in the First and Second Causes for Discipline above, are incorporated herein by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 51144, issued to John Alexander Cervantes, M.D.;

2. Revoking, suspending or denying approval of John Alexander Cervantes, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Alexander Cervantes, 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. If disciplined, ordering John Alexander Cervantes, M.D., to disclose his discipline to patients as required by section 2228.1 of the Code; and

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

DATED: SEP 27 2022

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

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