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

In the Matter of the First Amended Accusation Against: **JEFFREY EDWIN MAX, M.D.** **5755 Oberlin Drive, Suite 301** **San Diego, CA 92121-4717** **Physician's and Surgeon's Certificate No. C 50120,** Respondent.	Case No. 800-2020-071427 **FIRST AMENDED ACCUSATION** (Cal. Gov. Code, § 11507.)

Complainant alleges:

PARTIES

1. Reji Varghese (Complainant) brings this First Amended Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 5, 1998, the Medical Board issued Physician's and Surgeon's Certificate No. C 50120 to Jeffrey Edwin Max, 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 February 29, 2024, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on September 23, 2022, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> ...
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> (b) Gross negligence.
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

...

6. Unprofessional conduct is conduct which breaches rules or ethical codes of a profession or conduct which is unbecoming a member in good standing of a profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

COST RECOVERY

7. 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.

FACTUAL ALLEGATIONS

Patient A[1]

8. On or about October 6, 2015,[2] Patient A, a then 59-year-old male, first presented for treatment with Respondent. According to records, Patient A had a diagnosis of bipolar I disorder and was receiving treatment from another physician (Dr. T.J.), for his medication management. At the time of Patient A's first visit with Respondent, Patient A's medication regimen included,

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[1] For patient privacy purposes, the patient's true name is not used in the instant Accusation to maintain patient confidentiality. The patient's identity is known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery and in accordance with Government Code section 11507.6.

[2] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant Accusation is described for informational purposes only and not pleaded as a basis for disciplinary action.

but was not limited to, Synthroid,[3] Seroquel,[4] Trileptal,[5] gabapentin,[6] and clonazepam.[7] During this visit, Patient A requested Respondent provide psychotherapy, while Dr. T.J. continued providing Patient A's medication management.

9. On or about November 9, 2015, Patient A presented for treatment with Respondent. According to records, Patient A indicated he would like Respondent to continue Dr. T.J.'s medication management of Patient A when Dr. T.J. retired.

10. On or about January 18, 2016, Patient A sent his email exchanges with Dr. T.J. to Respondent. In the email exchanges dated January 18, 2016, Dr. T.J. informed Patient A, "As I said before, I am unwilling to go above 10 mg a day of clonazepam."

11. On or about January 28, 2016, Patient A contacted Respondent with a request that Respondent take over Patient A's medication management.

12. On or about January 29, 2016, Patient A presented for treatment with Respondent. According to records, Patient A informed Respondent that he wanted Respondent to take over

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[3] Synthroid is a brand name for levothyroxine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of thyroid disorders, such as hyperthyroidism.

[4] Seroquel is a brand name for quetiapine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic drug commonly used for the treatment of bipolar disorder and schizophrenia.

[5] Trileptal is a brand name for oxcarbazepine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of bipolar disorder, neuropathy and seizure disorders.

[6] Gabapentin, common brand names Neurontin and Gralise, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of pain, neuropathy, seizure disorders, fibromyalgia, and alcohol dependence.

[7] Clonazepam, common brand name Klonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a benzodiazepine commonly used for the treatment of seizure disorder, panic disorder, and anxiety. Benzodiazepines carry a Black Box Warning that states, in part, "Benzodiazepines expose users to risk of abuse, misuse, and addiction, can lead to overdose or death" and "concomitant benzodiazepine use with opioids may result in profound sedation, respiratory depression, coma and death; reserve concomitant use for patients with inadequate alternative treatment options; limit minimum required dosage and duration; monitor patients for signs or symptoms of respiratory depression and sedation."

Patient A's medication management. According to records, Patient A's medication regimen included, but was not limited to, gabapentin (900 mg, four times per day); Trileptal (300 mg, three times per day); clonazepam (4 mg once a day and 2 mg three times per day, for a total of 10 mg per day); and Saphris[8] (10 mg, two times per day).

13. On or about February 2, 2016, Patient A presented for treatment with Respondent. According to records, Patient A informed Respondent he had generalized anxiety disorder.

14. On or about February 9, 2016, Patient A presented for treatment with Respondent. According to records, Patient A informed Respondent he was taking up to 14 mg per day of clonazepam, even though only 10 mg per day was authorized.

15. On or about February 16, 2016, Patient A contacted Respondent and informed him he had taken an extra 4 mg of clonazepam to decrease his activation.[9] According to records, Patient A's medication regimen included, but was not limited to, Risperidone[10] (reduced from 6 mg to 4 mg, once every evening); gabapentin (1200 mg, three times per day); Synthroid (0.15 mg, one time per day, and 0.175 mg on Sundays), and Benadryl (150 mg, once every evening). According to records, Patient A informed Respondent he was no longer taking Trileptal, and that he had taken his final dose of Trileptal the night before. According to records, Patient A told Respondent it was "barbaric" for Respondent to not prescribe more than 10 mg of clonazepam per day to Patient A. According to records, Patient A was interested in trying lithium[11] at low doses,

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[8] Saphris is a brand name for asenapine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic drug commonly used for the treatment of bipolar disorder.

[9] Activation is a common symptom experienced by a person with bipolar disorder while in a manic state or episode. Common signs and symptoms during the manic phase include feeling unusually excited, increased energy, rapid speech, restlessness, poor concentration, and unusually high sex drive.

[10] Risperidone, common brand name Risperdal, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic drug commonly used for the treatment of bipolar disorder.

[11] Lithium, common brand names Lithobid and Eskalith, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of bipolar disorder.

but indicated past attempts had resulted in side effects, such as diarrhea. According to records, Respondent issued a prescription to Patient A for lithium (150 mg per day) and clonazepam (4 mg once a day, and 3 mg two times per day, for a total of 10 mg per day).

16. On or about February 17, 2016, Patient A contacted Respondent and informed him the lithium brought down his mood. Later that same day, according to records, Patient A contacted Respondent again and informed him he was going to begin taking L-Carnitine.[12]

17. On or about February 18, 2016, Patient A contacted Respondent with a request for an additional thirty (30) pills of clonazepam. According to records, Patient A indicated he was experiencing a lot of anxiety and "Klonipin [sic] withdrawal." According to records, Patient A indicated he was taking 10 mg per day, but was using more than prescribed and would run out. According to records, Respondent determined Patient A was not displaying "drug seeking abuse behavior" but rather his extra usage of clonazepam was due to the recent medication changes. According to records, Respondent issued a prescription to Patient A for an additional three (3) days' supply of clonazepam and noted his long term goal was to "get off Klonipin [sic]."

18. On or about February 19, 2016, Patient A contacted Respondent by telephone several times. During these conversations, according to records, Patient A informed Respondent he felt activated and requested to resume his prescription for lithium and requested a prescription for BuSpar.[13] According to records, Respondent issued a prescription to Patient A for lithium (150 mg, once per day).

19. On or about February 20, 2016, Patient A contacted Respondent and informed him the BuSpar was causing Patient A to be activated.

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[12] L-Carnitine is a brand name for levocarnitine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a nutritional supplement commonly used for the treatment of carnitine deficiency, a condition where nutrients are unable to reach your body's cells.

[13] BuSpar is a brand name for buspirone, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of depression.

20. On or about February 22, 2016, Patient A contacted Respondent with a request to redistribute his clonazepam intake schedule. According to records, Respondent agreed with Patient A's proposed rescheduling of his clonazepam.

21. On or about March 3, 2016, Patient A contacted Respondent with a request to redistribute his clonazepam intake schedule. According to records, Respondent agreed with Patient A's proposed rescheduling of his clonazepam.

22. On or about March 4, 2016, Patient A contacted Respondent and informed him the Trileptal was causing Patient A to feel depressed.

23. On or about March 6, 2016, Patient A contacted Respondent and informed him the Risperidone was no longer therapeutic.

24. On or about March 11, 2016, Patient A contacted Respondent and informed him that he had discontinued taking Risperidone.

25. On or about May 10, 2016, Patient A contacted Respondent and reported suicidal ideation. According to records, Respondent began prescribing Wellbutrin[14] to Patient A.

26. On or about May 16, 2016, Patient A contacted Respondent and reported the Wellbutrin was causing Patient A to be activated, and that he was resuming lithium (300 mg, three times per day).

27. On or about May 17, 2016, Patient A contacted Respondent and reported the lithium was causing a reduction in Patient A's libido, so Patient A had reduced his lithium to 750 mg per day and continued to maintain clonazepam at 10 mg per day.

28. On or about May 23, 2016, Patient A contacted Respondent and reported falling, resulting in possibly dislocating his shoulder. According to records, Patient A reported he believed there was no medication regimen that would help him, and that he would kill himself if nothing else worked.

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[14] Wellbutrin is a brand name for bupropion hydrochloride, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a norepinephrine-dopamine reuptake inhibitor (NDRI) commonly used for the treatment of major depressive disorder, seasonal affective disorder (SAD) and attention deficit hyperactivity disorder (ADHD).

29. On or about May 27, 2016, Patient A contacted Respondent and reported feeling very despondent and suicidal, but having "no good means to kill himself." According to records, Patient A was interested in trying ketamine.[15]

30. On or about May 31, 2016, Patient A contacted Respondent and reported he was no longer participating in physical therapy because it was not helping. According to records, Patient A's medication regimen included, but was not limited to lithium (750 mg per day), Mirapex[16] (0.25 mg per day); Trileptal (300 mg, three times per day); gabapentin (900 mg, three times per day); clonazepam (10 mg per day); and Synthroid (0.25 mg per day). Later that same day, Patient A contacted Respondent again and reported he felt he was "ramping up" and was interested in another neuroleptic. According to records, Respondent increased Patient A's lithium from 750 mg per day to 900 mg per day and increased Patient A's gabapentin from 900 mg three times per day to 900 mg four times per day. Respondent also noted a plan to consider Abilify[17] as another neuroleptic.

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[15] Ketamine, common brand name Ketalar, is an analgesic sedative that is a Schedule III controlled substances pursuant to Health and Safety Code section 11056, subdivision (g), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for general anesthesia and may be used for the treatment of pain and depression. Ketamine can be administered through various means, including, but not limited to, intravenous (IV) injection, intramuscular injection (IM), or intranasally (IN).

[16] Mirapex is a brand name for pramipexole, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of Parkinson's disease and restless legs syndrome.

[17] Abilify is a brand name for aripiprazole, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic commonly used for the treatment of bipolar disorder, schizophrenia and major depressive disorder.

31. On or about June 13, 2016, Patient A contacted Respondent and reported he was no longer taking Percocet[18] because it caused him to feel depressed. According to records, Patient A's current lithium dose was lowered to 750 mg per day.

32. On or about July 25, 2016, Patient A contacted Respondent and reported he had tried Depakote[19] which he believed had a direct myopathic effect on Patient A. According to records, Patient A's medication regimen included, but was not limited to, lithium (750 mg per day); gabapentin (900 mg, three times per day); Trileptal (300 mg, three times per day); clonazepam (10 mg per day); and Synthroid (0.15 mg per day). According to records, Patient A had discontinued taking Mirapex.

33. On or about August 5, 2016, Patient A contacted Respondent and reported he would no longer take ketamine as it was exacerbating his myopathy. According to records, Respondent planned for Patient A to resume Mirapex.

34. On or about August 23, 2016, Respondent completed a disability statement for Patient A's insurance. According to records, Respondent indicated Patient A's current diagnoses to include, bipolar disorder complicated by myopathy, obesity, sleep apnea, hypothyroidism, hypogonadism, disabling unstable mood, mostly depressed, but activated with mixed manic symptoms.

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[18] Percocet is a brand name for a combination drug containing oxycodone and acetaminophen, it is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an opioid commonly used for the treatment of pain. The Drug Enforcement Administration (DEA) has identified oxycodone as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2015 Edition, at pg. 43). Opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk prior to prescribing; monitor all patients for misuse, abuse, and addiction" and "concomitant opioid use with benzodiazepines…may result in profound sedation, respiratory depression, coma, and death; reserve concomitant use for patients with inadequate alternative treatment options; limit to minimum required dosage and duration."

[19] Depakote is a brand name for divalproex sodium, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of bipolar disorder, seizures, and migraines.

35. On or about September 21, 2016, Patient A contacted Respondent and reported he was no longer taking Seroquel due to side effects, including myopathy. According to records, Lexapro[20] was added to Patient A's medication regimen.

36. On or about October 15, 2016, Patient A contacted Respondent and reported the Lexapro was causing Patient A's mood to worsen.

37. On or about November 11, 2016, Patient A contacted Respondent with complaints of persistent depression. According to records, Patient A rejected Respondent's recommendations to consider psychosocial and pharmacological changes. However, Patient A did agree to maintain his appointment with P.L., a clinical psychologist, for cognitive behavioral therapy (CBT).

38. On or about November 15, 2016, P.L. emailed Respondent with an update on his appointment with Patient A. According to the email, P.L. described Patient A as having a "controlling nature" and having a "high need for control." According to the email, P.L. felt Patient A attended the appointment "primarily to fulfill [Respondent's] recommendation and referral" and to look "for a reason to dismiss [P.L.]."

39. On or about December 13, 2016, Patient A contacted Respondent and reported he was considering suicide before his next birthday. According to records, Respondent recommended another CBT referral, but Respondent declined.

40. On or about January 5, 2017, Patient A contacted Respondent and reported feeling extremely depressed and suicidal. According to records, Respondent issued a prescription for Patient A to begin a low dose of Vyvanse.[21]

41. On or about January 30, 2017, Patient A contacted Respondent and reported his success with Vyvanse. According to records, Patient A's medication regimen included, but was

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[20] Lexapro is a brand name for escitalopram, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a non-benzodiazepine selective serotonin reuptake inhibitor (SSRI) commonly used for the treatment of major depressive disorder and generalized anxiety disorder.

[21] Vyvanse is a brand name for lisdexamfetamine, it is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a CNS stimulant commonly used for the treatment of ADHD.

not limited to, clonazepam (10 mg per day); Trileptal (300 mg, three times per day); gabapentin (900 mg, three times per day); lithium (750 mg per day); Vyvanse (0.5 mg every morning); and Synthroid (0.15 mg per day). According to records, Patient A was not interested in changing his medications.

42. On or about February 27, 2017, Patient A contacted Respondent and reported experiencing sleep disturbance due to depression and sleep apnea. According to records, Patient A considered lowering his lithium and increasing his Vyvanse to 1.5 mg every morning.

43. On or about April 9, 2017, Patient A contacted Respondent and reported experiencing increased irritability. According to records, Patient A and Respondent decided to discontinue Vyvanse and Lexapro, as Patient A believed these were causing him to be more irritable.

44. On or about June 13, 2017, Patient A contacted Respondent and reported feeling activated. According to records, Respondent increased Patient A's gabapentin from 2,700 mg per day to 3,600 mg per day.

45. On or about June 19, 2017, Patient A presented for a visit with Respondent. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (10 mg per day); Trileptal (300 mg, three times per day); gabapentin (900 mg, three times per day); lithium (750 mg per day); and Synthroid (0.15 mg per day).

46. On or about August 1, 2017, Patient A presented for a visit with Respondent. According to records, Patient A had resumed taking Lexapro and felt it was effectively reducing his depression.

47. On or about August 22, 2017, Patient A contacted Respondent and reported increasing levels of depression and irritability. According to records, Respondent decreased Patient A's Lexapro from 0.7 mg every morning to 0.3 mg every morning, and increased Patient A's lithium from 750 mg per day to 900 mg per day.

48. On or about August 30, 2017, Patient A contacted Respondent and reported still feeling depressed and irritated. According to records, Respondent increased Patient A's Vyvanse from 0.5 mg every morning to 1 mg every morning.

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49. On or about September 1, 2017, Patient A left a message for Respondent reporting he was still feeling depressed. According to records, Patient A stated he "will not do nothing" and needed to make a change. According to records, Patient A indicated he would decrease his Lexapro, Vyvanse and gabapentin.

50. On or about September 4, 2017, Patient A contacted Respondent and reported feeling significant relief when he unilaterally increased his clonazepam from 10 mg per day to 14 mg per day.

51. On or about September 5, 2017, Respondent noted Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); lithium (750 mg per day); gabapentin (900 mg, three times per day); Trileptal (300 mg, three times per day); and Lexapro (0.7 mg per day). According to records, Patient A was willing to try electroconvulsive therapy (ECT) and Respondent provided a referral for ECT.

52. On or about September 16, 2017, Patient A contacted Respondent and reported his depression was worsening. According to records, Patient A was determined not to be a candidate for ECT due to his numerous anticonvulsant medications. According to records, Patient A's lithium was increased to 900 mg per day.

53. On or about October 10, 2017, Patient A contacted Respondent and reported feeling better and believed it to be a result of his increase in clonazepam to 12 mg per day.

54. On or about November 21, 2017, Patient A contacted Respondent and reported having issues falling asleep, but was able to sleep after taking a "more than usual" amount of clonazepam. According to records, Patient A believed he had "stumbled upon the right combination" of medications.

55. On or about December 4, 2017, Patient A contacted Respondent and reported his depression was worsening. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (12 mg per day); lithium (600 mg per day); gabapentin (900 mg, three times per day); Trileptal (300 mg, three times per day); and Lexapro (1 mg per day). According to records, Patient A was to increase his Lexapro and lithium.

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56. On or about December 7, 2017, Patient A left a message for Respondent reporting he had increased his Lexapro to 1.5 mg every morning and was scheduled for a ketamine dose the next day.

57. On or about December 9, 2017, Patient A contacted Respondent indicating he had a positive response to ketamine, but wanted to reduce his Lexapro from 1.5 mg every morning to 1.2 to 1.3 mg every morning.

58. On or about December 13, 2017, Patient A contacted Respondent to report he was experiencing issues walking and his mood had worsened in response to ketamine.

59. On or about January 30, 2018, Patient A contacted Respondent and reported feeling suicidal and taking extra clonazepam.

60. On or about March 6, 2018, Patient A contacted Respondent and reported feeling less irritable without Lexapro. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); lithium (900 mg per day); gabapentin (900 mg, three times per day); and Trileptal (300 mg, three times per day).

61. On or about May 11, 2018, Patient A contacted Respondent and reported his mood was declining. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (12 mg per day); lithium (600 mg per day); gabapentin (900 mg, three times per day); and Trileptal (300 mg, three times per day).

62. On or about May 19, 2018, Patient A contacted Respondent with a request to increase his lithium and decrease his mood stabilizers. According to records, Respondent suggested trying a low dose of desipramine[22] and contacted a compounding pharmacy to prepare a low dose for Patient A.

63. On or about June 7, 2018, Patient A contacted Respondent and reported feeling excessively tired. According to records, Patient A indicated he used his sleep apnea mask and felt well-rested. According to records, Patient A's medication regimen included, but was not limited

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[22] Desipramine, common brand name Norpramin, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a tricyclic antidepressant commonly used for the treatment of depression.

to, clonazepam (12 mg per day); lithium (600 mg per day); gabapentin (900 mg, three times per day); and Trileptal (300 mg, three times per day).

64. On or about August 7, 2018, Patient A presented for treatment with Respondent. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (9 mg per day); lithium (600 mg per day); gabapentin (900 mg, three times per day); and Trileptal (300 mg, two times per day). According to records, Patient A had also recently started taking Vraylar.[23] According to records, Patient A also reported feeling "very shaky" and believed he was experiencing withdrawal from clonazepam. Patient A reported he was "habituated" to clonazepam. According to records, Respondent indicated Patient A was to discontinue taking gabapentin and Trileptal, and increase his prescription for Vraylar.

65. On or about August 8, 2018, Patient A contacted Respondent and reported Vraylar was causing him significant motor impairment.

66. On or about August 14, 2018, Patient A sent Respondent a series of emails between 1:30 AM and 5:30 AM, in which Patient A indicated he would increase to 900 mg of lithium, that he was unable to sleep and had taken an additional four (4) clonazepam, then changed his mind about taking lithium.

67. On or about August 17, 2018, Patient A contacted Respondent and reported he was doing well on the increased dose of lithium.

68. On or about August 19, 2018, Patient A contacted Respondent and reported the 900 mg per day of lithium was causing him to feel "slowness" and requested to resume taking gabapentin (300 mg, three times per day).

69. On or about August 20, 2018, Patient A contacted Respondent and reported he felt "level" while maintaining his lithium dose at 150 mg, two times per day.

70. On or about September 26, 2018, Patient A contacted Respondent and reported he had decided to move to Florida.

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[23] Vraylar is a brand name for cariprazine, it is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic commonly used for the treatment of bipolar disorder and schizophrenia.

71. On or about October 2, 2018, Patient A contacted Respondent from Florida and reported his decision to move to Florida was caused by his depression and that he planned to return to California.

72. On or about October 9, 2018, Patient A presented for treatment with Respondent. According to records, Patient A's lithium dose of 1,050 mg was too much and caused irritability, and would lower his lithium to 900 mg per day. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); lithium (900 mg per day); Trileptal (300 mg, three times per day); Lexapro (0.7 mg every morning), and Vyvanse (0.5 mg every morning). According to records, Patient A had stopped taking gabapentin for several weeks.

73. On or about November 6, 2018, Patient A presented for treatment with Respondent. According to records, Patient A reported he had resumed taking gabapentin (300 mg, three times per day), discontinued taking Lexapro and Vyvanse, and was trying to maintain lithium at 750 mg per day and clonazepam at 13 mg per day.

74. On or about November 20, 2018, Respondent documented receiving several phone calls from Patient A over the past several days. According to records, Patient A contacted Respondent and reported feeling depressed. According to records, Patient A agreed to discontinue lithium and discontinue Lexapro. Later, Patient A reported feeling activated and wanted to increase his lithium and gabapentin. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); lithium (600 mg per day); gabapentin (1,800 mg per day); Trileptal (300 mg, three times per day); Lexapro (1 mg every morning), and Tenuate[24] (15 mg, two times per day).

75. On or about November 21, 2018, Patient A contacted Respondent and reported feeling irritable and activated. According to records, Respondent and Patient A discussed the possibility of discontinuing gabapentin and Trileptal and increasing Patient A's lithium.

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[24] Tenuate is a brand name for diethylpropion, it is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057 subdivision (f), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is commonly used for the treatment of obesity.

76. On or about November 26, 2018, Patient A contacted Respondent and reported he was "cycling quite a bit." According to records, Patient A reported he had discontinued Tenuate and gabapentin, and that he was discontinuing Trileptal that day. According to records, Patient A also reported taking 900 mg of lithium per day, but considered increasing to 1,200 mg per day. According to records, Patient A also reported taking 12 to 14 mg of clonazepam to assist him in discontinuing his mood stabilizers.

77. On or about December 12, 2018, Respondent documented receiving several phone calls from Patient A over the past several days. According to records, Patient A expressed suicide ideation and reported experiencing severe depression. According to records, Patient A and Respondent discussed the possibility of discontinuing clonazepam which would allow Patient A to be eligible for ECT. According to records, Respondent issued a prescription for nortriptyline[25] (10 mg every evening), his first tricyclic antidepressant.

78. On or about December 15, 2018, Patient A contacted Respondent and reported he discontinued taking nortriptyline because it caused him to experience reflux and that Patient A received no benefit from taking nortriptyline. According to records, Respondent recommended Patient A lower his clonazepam from 14 mg per day to a dose that would allow Patient A to be eligible for ECT.

79. On or about January 4, 2019, Patient A contacted Respondent and reported he was determined to undergo bariatric surgery. According to records, Respondent agreed bariatric surgery was indicated and safe for Patient A.

80. On or about January 21, 2019, Patient A contacted Respondent and reported he had restarted Trileptal and gabapentin. According to records, Patient A requested to stop lithium due to side effects felt in his muscles and hair loss. According to records, Patient A continued to take clonazepam (14 mg per day) and nortriptyline (0.4 mg every morning).

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[25] Nortriptyline, brand name Pamelor, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is a tricyclic/tetracyclic antidepressant (TCAs/TeCAs) commonly used for the treatment of depression.

81. On or about February 13, 2019, Respondent documented a series of phone calls from Patient A over the past two days. According to records, Patient A reprimanded Respondent for failing to point out his recent calls and email correspondence were signs of escalating mania. According to records, Respondent and Patient A agreed to increase his lithium to 300 mg, three times per day.

82. On or about March 21, 2019, Patient A presented for treatment with Respondent. According to records, Patient A reported feeling stable for the past six (6) weeks. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); nortriptyline (0.4 mg every evening); Trileptal (600 mg, two times per day); gabapentin (300 mg, three times per day); and lithium (150 mg, two times per day).

83. On or about April 9, 2019, Patient A contacted Respondent and reported experiencing blurred vision. According to records, Patient A believed the blurred vision was caused by his increase in gabapentin and Trileptal.

84. On or about April 18, 2019, Patient A contacted Respondent and reported feeling depressed. Patient A informed Respondent he had discontinued lithium because it was causing him to have diarrhea. According to records, Patient A also reported discontinuing nortriptyline and wanted to increase his Trileptal to 1,500 mg per day.

85. On or about April 21, 2019, Patient A contacted Respondent and reported he had failed in a suicide attempt. According to records, Patient A had cut his wrists, neck and groin area. Respondent called 9-1-1 and Patient A was brought to the hospital for treatment.

86. On or about May 1, 2019, Respondent was contacted by the hospital psychiatrist who was providing treatment to Patient A while hospitalized. According to records, Respondent recommended a careful taper off clonazepam.

87. On or about May 24, 2019, Patient A presented for treatment with Respondent. According to records, this was Patient A's first office visit with Respondent since his suicide attempt. According to records, Patient A's medication regimen included, but was not limited to,

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clonazepam (3 mg, three times per day, with an additional 3 mg per day as needed); Trileptal (150 mg, three times per day); and nortriptyline (0.075 mL every evening). According to records, Respondent issued a new diagnoses of dysarthria[26] for Patient A with no known cause.

88. On or about June 17, 2019, Patient A presented for treatment with Respondent. According to records, Patient A reported an increase in anxiety from the reduction in clonazepam. According to records, Respondent increased Patient A's clonazepam back to 14 mg per day.

89. On or about July 2, 2019, Patient A contacted Respondent and informed Respondent that he had moved to Philadelphia and was waiting to be accepted into a rehabilitation center there. According to records, Patient A reported feeling "a bit high" before leaving San Diego, so he "loaded up on lithium" and now was feeling depressed and suicidal. According to records, Respondent's plan for Patient A was to taper his clonazepam by 1 mg every two (2) weeks.

90. On or about July 18, 2019, Patient A contacted Respondent and reported he was moving to Florida in August. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (11 mg per day); gabapentin (2,700 mg per day); Trileptal (900 mg per day); and lithium (600 mg per day).

91. On or about August 27, 2019, Patient A contacted Respondent and reported he was settling into Florida and planned to attend a bipolar support group the next day.

92. On or about October 21, 2019, Respondent documented a series of phone calls from Patient A over the past several days. According to records, Respondent agreed to continue contact with Patient A, but noted it would not be for therapy or medical advice, as Patient A was now under the care and treatment of a physician in Florida.

93. On or about January 16, 2020, Respondent documented receiving multiple calls from Patient A for the past month. According to records, Patient A requested and Respondent agreed to provide psychotherapy support for Patient A. According to records, Patient A was unable to obtain a prescription for Vyvanse in Florida, so Respondent agreed to prescribe Vyvanse to Patient A so long as Patient A returned to California for an in person visit three (3) to four (4)

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[26] Dysarthria is a condition in which one experiences slurred speech or difficulty speaking as a result of weakness in the muscles.

times per year. According to records, Patient A reported to Respondent he was now receiving narcotic medications to treat his pain from his self-inflicted tendon wounds.

94. On or about February 8, 2020, Patient A contacted Respondent and reported feeling lonely and depressed. According to records, Patient A reported entertaining suicidal thoughts but had no intention to carry them out. Patient A also informed Respondent that he purchased a firearm upon moving to Florida, and in the event he did plan to kill himself, he would succeed.

95. On or about February 12, 2020, Patient A contacted Respondent and reported feeling better after discontinuing Vyvanse and increasing Lexapro. According to records, Patient A still possessed his gun and felt it provided him with some sense of control.

96. On or about February 19, 2020, Patient A contacted Respondent and reported he was attempting to reduce his Percocet. According to records, Patient A reported his medication regimen included, but was not limited to, Vyvanse (0.5 mg every other day); Lexapro (0.15 mg every morning); clonazepam (14 mg per day); and Percocet (10 mg three to five times per day).

97. On or about March 8, 2020, Patient A contacted Respondent and reported feeling suicidal and admitted he still possessed his gun. According to records, Patient A decided to move to Texas and decided to sell his gun to avoid transporting it across state lines.

98. On or about March 18, 2020, Patient A contacted Respondent and reported he had moved to San Antonio.

99. On or about March 19, 2020, Patient A left a message for Respondent identifying his current medications to include lithium (300 mg, two times per day), Trileptal (300 mg, three times per day), gabapentin (300 mg, three times per day), and clonazepam (14 mg per day).

100. On or about April 10, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported a deterioration in mood to the verge of suicide. According to records, Patient A wrote a suicide note praising Respondent and then decided to move back to California.

101. On or about April 13, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A was involved in a single vehicle accident while driving back to California.

102. On or about April 21, 2020, Patient A contacted Respondent and reported feeling weak and feverish. According to records, Patient A decided to discontinue taking gabapentin, Trileptal and lithium, but then agreed to resume Trileptal and gabapentin at lower doses. According to records, Patient A was to continue his prescription for clonazepam (14 mg per day) with a plan to attempt to taper again.

103. On or about April 22, 2020, Patient A contacted Respondent and reported discontinuing Trileptal, gabapentin and lithium. According to records, Patient A maintained clonazepam at 12 to 14 mg per day. According to records, Patient A also reported feeling suicidal and taking twelve (12) Percocet pills. According to records, Patient A agreed to resume Lexapro (0.3 mg every morning).

104. On or about April 27, 2020, Patient A contacted Respondent and reported cancelling his appointment with a pain doctor. According to records, Patient A planned to obtain "another month of narcotic" medications as a "stash" for a potential future suicide attempt.

105. On or about April 28, 2020, Patient A contacted Respondent and reported taking Percocet then losing interest in suicide. According to records, Patient A agreed to lower his clonazepam to 12 mg per day due to cognitive impairment. Later that same day, Patient A contacted Respondent and reported he desired to detoxify without being admitted to rehabilitation or a hospital. According to records, Respondent noted, "It is clear the combination of his percoset [sic] + klonipin [sic] is causing cognitive problems, disorientation, delirium including intermittent visual hallucinations." According to records, Respondent noted a plan to attempt to taper Patient A's clonazepam.

106. On or about April 29, 2020, Patient A contacted Respondent and reported he was feeling extremely suicidal. According to records, Patient A was willing to attend a rehabilitation center, but changed his mind.

107. On or about May 1, 2020, Patient A presented for treatment with Respondent. According to records, this was Respondent's first in person visit with Patient A in eleven (11) months. According to records, Patient A "staggered into the office, supporting himself with his arms on the opposing walls." According to records, Patient A's medication regimen included, but

was not limited to, clonazepam (10 mg per day); gabapentin (600 mg, three times per day); Trileptal (300 mg, two times per day); and lithium (300 mg, two times per day).

108. On or about May 8, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported making plans to commit suicide. According to records, Respondent contacted another physician, Dr. D.B., to provide Patient A with IV ketamine. According to records, Patient A was to continue receiving ketamine two times per week and taper his clonazepam "as much as possible gradually (14 mg - 10 mg)."

109. On or about May 11, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported a "non-linear" response to ketamine. According to records, Respondent suggested Patient A make no changes to his medication regimen, however, Patient A decreased his gabapentin, and discontinued lithium and Trileptal.

110. On or about May 13, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported the ketamine was not effective and that it was causing his myopathy to worsen. According to records, Patient A also reported taking multiple extra clonazepam tablets in an attempt to overdose.

111. On or about May 20, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported saving his Percocet for a future suicide attempt. According to records, Patient A left five (5) messages for Respondent requesting that he convince Patient A's physician (Dr. B.B.) to continue prescribing Percocet to Patient A, despite Patient A's recent attempt to overdose taking twenty (20) pills in a "half-hearted suicide attempt." According to records, when Dr. B.B. refused to continue treating Patient A after learning Patient A had taken twenty (20) Percocet pills, Patient A threatened to kill himself and that his death "would be on [Dr. B.B.]'s hands."

112. On or about May 29, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported he tripped and suffered a concussion.

113. On or about June 9, 2020, Patient A contacted Respondent and reported he had consulted with an addiction specialist in Philadelphia. According to records, they had concluded Patient A's pain, analgesia and diarrhea were all related to narcotic withdrawal and would be managed with a 6-week taper. According to records, afterwards, Patient A would then attempt to taper his clonazepam.

114. On or about June 12, 2020, Patient A contacted Respondent and reported presenting to the emergency department with complaints of subdural hemorrhage and being discharged without any examination. According to records, Patient A was complaining of suffering from Alzheimer's disease and dementia. According to records, Patient A was struggling from withdrawal from Percocet and wanted a prescription for buprenorphine transdermal patches.[27]

115. On or about June 15, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A exhibited paranoid ideation and Respondent requested Patient A attend in person for a mental assessment. Later that same day, Patient A presented at Respondent's office. According to records, Patient A continued to exhibit paranoia and during his mental assessment, Patient A drew a partially incorrect clock and refused to participate in a memory test. According to records, Respondent recommended Patient A resume lithium (300 mg, two times per day) and noted Patient A "needs narcotic withdrawal."

116. On or about June 19, 2020, Patient A contacted Respondent while receiving treatment at a local hospital. According to records, Patient A reported his medication regimen included, but was not limited to, lithium (300 mg, two times per day); gabapentin (600 mg, four times per day); Trileptal (300 mg, two times per day) and clonazepam (14 mg per day). According to records, Patient A requested Respondent refill his medications early, stating he had thrown them away because he believed his assistant had contaminated his medications.

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[27] Buprenorphine transdermal patch, common brand name Butrans, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an opioid commonly used for the treatment of pain.

117. On or about June 22, 2020, Respondent documented receiving multiple calls and voice messages from Patient A over the past several days. According to records, Patient A reported being admitted to a hospital on a suicide watch, during which time Patient A engaged in behavior the hospital staff determined to be sexually inappropriate. According to records, Patient A requested a one-day supply of clonazepam and mood stabilizers while he waited for his usual pharmacy to reopen after the weekend. Patient A also reported he had flushed several Percocet tablets he found on the bed in his hotel, believing they had been planted there in some conspiracy, only to later realize the Percocet pills were his own.

118. On or about June 30, 2020, Respondent documented receiving multiple calls and voice messages from Patient A overnight. According to records, Patient A reported experiencing nausea from "lithium toxicity." According to records, Respondent lowered Patient A's lithium dose while maintaining clonazepam at 14 mg per day and increasing gabapentin to 900 mg, four times per day.

119. On or about July 3, 2020, Patient A contacted Respondent and reported feeling depressed and requested ketamine. According to records, Respondent noted Patient A was over sedated and planned to decrease Patient A's clonazepam by 1 mg per week if possible. According to records, Patient A's lithium was lowered to 150 mg, two times per day, and Trileptal was discontinued.

120. On or about July 8, 2020, Patient A contacted Respondent and reported he felt they had reached an impasse in their relationship. According to records, Patient A insisted Respondent assist him in transferring his care to a new psychiatrist. According to records, Patient A's medication regimen included, but was not limited to, gabapentin (2,700 mg per day) and clonazepam (14 mg per day). According to records, Patient A was also scheduled to begin buprenorphine transdermal patch that same day.

121. Throughout the month of July 2020, Respondent documented several calls with potential treatment providers. According to records, multiple physicians expressed concern over the high dose of clonazepam prescribed to Patient A and refused to accept Patient A as a patient.

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122. On or about July 17, 2020, Respondent documented a message left by Patient A. According to records, Patient A reported feeling irritable, sad and suicidal. According to records, Patient A indicated he was going through narcotic withdrawal and believed a higher dose of clonazepam was warranted. According to records, Patient A indicated he had an appointment with a new physician at the end of the month.

123. On or about July 20, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported falling asleep while driving resulting in damage to his vehicle.

124. On or about August 13, 2020, Patient A contacted Respondent requesting to decrease his lithium, Trileptal, and gabapentin, reporting it was causing a decrease in his sexual function.

125. On or about September 4, 2020, Patient A contacted Respondent and reported suffering a concussion after falling in the shower.

126. On or about October 5, 2020, Patient A contacted Respondent and reported suicidal ideation and plans to purchase a firearm. According to records, Patient A requested a refill of his prescription for clonazepam and Respondent agreed to issue a one-week supply. According to records, Patient A was unhappy with Respondent only issuing a one-week supply of clonazepam and reported experiencing narcotic withdrawal.

127. On or about October 6, 2020, Patient A was hospitalized on a 72-hour hold for his safety. During Patient A's hospitalization, according to records, Patient A's clonazepam was limited to 6 mg per day. According to records, Patient A contacted Respondent and reported he was not receiving enough clonazepam. According to records, Respondent contacted the hospital staff physician and requested they provide Patient A with additional clonazepam. According to records, Respondent informed the hospital that Patient A needed 14 mg of clonazepam per day and that Patient A may otherwise go into withdrawal.

128. On or about October 9, 2020, Patient A left the hospital against medical advice after obtaining a court order to remove an extended psychiatric hold beyond the 72-hour hold.

129. On or about November 8, 2020, Patient A contacted Respondent and reported taking additional clonazepam, Trilpetal and lithium, because he was feeling activated. According to

records, Patient A had discontinued Vyvanse and was scheduled to receive a ketamine infusion in a few days.

130. On or about November 17, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported taking extra clonazepam due to his activated state.

131. On or about December 29, 2020, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported success with his weekly ketamine infusions. According to records, Patient A's medication regimen included, but was not limited to, clonazepam, Trileptal, lithium, gabapentin and buprenorphine transdermal patch.

132. On or about January 24, 2021, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported continued success with his weekly ketamine infusions. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); gabapentin (900 mg, three times per day); Trileptal (300 mg, two times per day); lithium (300 mg, two times per day); Lexapro (0.5 mg every morning); Vyvanse (0.5 mg every morning); and ketamine.

133. On or about February 8, 2021, Respondent documented receiving multiple calls from Patient A over the past several days. According to records, Patient A reported experiencing rapidly escalating depression and suicidal ideation.

134. On or about February 10, 2021, Patient A contacted Respondent to report concerns about his sleep apnea. According to records, Patient A was scheduled to visit a respiratory therapist in two (2) days and agreed to attempt to taper his clonazepam to 13 mg per day.

135. On or about February 11, 2021, Patient A contacted Respondent and reported he was less interested in decreasing his clonazepam.

136. On or about February 17, 2021, Patient A contacted Respondent and reported "bouncing off the walls" in a manic state. According to records, Patient A and Respondent agreed to discontinue Lexapro and Vyvanse, and increase gabapentin to 1,200 mg, three times per day, and increase Trileptal to 600 mg, two times per day.

137. On or about February 18, 2021, Patient A contacted Respondent and reported his moods were "cycling." According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); gabapentin (1,200 mg, three times per day); Trileptal (600 mg, two times per day); and lithium (300 mg, two times per day).

138. On or about February 22, 2021, Respondent documented receiving multiple calls from Patient A. According to records, Patient A's depression was worsening and Patient A had "unilaterally restarted" Vyvanse and Lexapro and planned to receive his weekly ketamine infusion.

139. On or about February 27, 2021, Respondent documented receiving multiple calls from Patient A. According to records, Patient A was in a mixed manic and depressed state. According to records, Patient A agreed to begin perphenazine[28] (4 mg every evening) and decrease gabapentin to 600 mg, three times per day, and decrease clonazepam to 12 mg per day.

140. On or about March 1, 2021, Patient A contacted Respondent and reported he had discontinued perphenazine because it was causing Patient A to experience myopathy. According to records, Patient A also reported resuming Vyvanse (1 mg), and increasing his other medications, including, but not limited to, gabapentin (600 mg, four times per day), Trileptal (600 mg, two times per day); lithium (300 mg, three times per day); and clonazepam (14 mg per day). According to records, Patient A also reported ketamine was no longer helpful and caused him to experience hypomania or mixed state.

141. On or about March 8, 2021, Patient A contacted Respondent and reported he would run out of monetary funds in eight (8) months, and that he planned to kill himself at that time.

142. On or about March 10, 2021, Patient A contacted Respondent and reported significant depression. According to records, Patient A reported he has attempted to work with Respondent to obtain mood stabilization but has continued to suffer. According to records, Patient A's medication regimen included, but was not limited to, clonazepam (14 mg per day); gabapentin

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[28] Perphenazine, brand name Trilafon, is a dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is an antipsychotic commonly used for the treatment of schizophrenia and nausea.

(900 mg, three times per day); Trileptal (1,500 mg per day); lithium (1,200 mg per day), and Butrans transdermal patch (5 mcg).

143. From on or about October 6, 2015, through on or about March 10, 2021, throughout Patient A's treatment with Respondent, records indicate Patient A and Respondent were in constant contact on a near daily basis, and on numerous occasions, having multiple points of contact per day. According to records, Patient A's contact with Respondent was often times outside of scheduled appointments.

144. From on or about October 6, 2015, through on or about March 10, 2021, throughout Patient A's treatment with Respondent, records indicate Patient A's weight fluctuated but remained at or around 250 pounds.

145. In or around 2018, according to the Controlled Substance Utilization Review and Evaluation System (CURES),[29] Respondent issued nine (9) monthly prescriptions to Patient A for 420 tablets of clonazepam (1 mg).

146. In or around 2019, according to CURES, Respondent issued seven (7) monthly prescriptions to Patient A for 420 tablets of clonazepam (1 mg).

147. In or around 2020, according to CURES, Respondent issued six (6) monthly prescriptions to Patient A for 420 tablets of clonazepam (1 mg).

148. In or around 2021, according to CURES, Respondent continued to issue monthly prescriptions to Patient A for 420 tablets of clonazepam (1 mg).

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[29] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

149. According to the CURES report for Patient A, from in or around 2018, through in or around 2021, Patient A received and filled several prescriptions for controlled substances, issued by other physicians, including, but not limited to, prescriptions for clonazepam, Percocet, buprenorphine, and Vyvanse.

150. From on or about October 6, 2015, through on or about March 10, 2021, throughout Patient A's treatment with Respondent, records do not document any requests or orders by Respondent for Patient A to provide a urine sample for toxicology screening to monitor for drug abuse, misuse, or diversion.

151. From on or about October 6, 2015, through on or about March 10, 2021, throughout Patient A's treatment with Respondent, records do not document any referrals by Respondent for Patient A to be evaluated by an addiction specialist.

152. From on or about October 6, 2015, through on or about March 10, 2021, throughout Patient A's treatment with Respondent, records do not document any requests or orders by Respondent for Patient A to enroll in a rehabilitation and/or detoxification program.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

153. Respondent has subjected his Physician's and Surgeon's Certificate No. C 50120 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A, including, but not limited to:

A. Paragraphs 8 through 152, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to limit the dose and duration of his prescriptions for clonazepam to Patient A, prescribing an average of 14 mg per day on a regular basis over six (6) years;

C. Respondent failed to avoid prescribing high doses of clonazepam and other medications, including, but not limited to, gabapentin and Trileptal, to Patient A who was approaching 65 years of age;

D. Respondent failed to avoid prescribing high doses of clonazepam to Patient A, who was also receiving prescriptions for opioids by other physicians;

E. Respondent failed to set appropriate limits and boundaries in his treatment of Patient A to maintain the necessary structure and control of Patient A's treatment;

F. Respondent failed to employ evidence-based therapeutics in his care and treatment of Patient A, and instead engaged in irrational polypharmacy in his treatment of Patient A's bipolar disorder, allowing Patient A to constantly modify his medication regimen without allowing the necessary time for medications to become effective;

G. Respondent failed to order any urine toxicology screens for Patient A to monitor for medication compliance and review for evidence of drug abuse, misuse, or diversion; and

H. Respondent failed to refer Patient A to a substance abuse treatment program and/or an addiction specialist for evaluation, diagnosis and detoxification.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

154. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 50120 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, including, but not limited to:

A. Paragraphs 8 through 153, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

B. Respondent failed to order any neuropsychiatric and personality testing of Patient A despite evidence of misdiagnosis and/or treatment failure.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

155. Respondent has also subjected his Physician's and Surgeon's Certificate No. C 50120 to disciplinary action under section 2227 and 2234, in that he engaged in conduct which breached

a rule or ethical code of the medical profession or engaged in conduct which was unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 154, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 50120, issued to Respondent Jeffrey Edwin Max, M.D.;
2. Revoking, suspending or denying approval of Respondent Jeffrey Edwin Max, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent Jeffrey Edwin Max, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: JUN 22 2023

JENNA JONES FOR
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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